The prevalence and predictors of intimate partner violence among women attending a midwife and obstetrics unit in the Western Cape.

MPhil Public Mental Health

Thesis Paper

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DECLARATION

I, Megan Malan hereby declare that the work on which this dissertation/thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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Abstract

Background: Intimate partner violence (IPV) during pregnancy is a common phenomenon across the world. The present study sought to determine the prevalence and predictors of intimate partner violence among pregnant women attending a midwife and obstetrics unit in the Western Cape.

Methods: A convenience sample of a hundred and fifty pregnant women (n= 150) attending antenatal appointments at the Mitchell's Plain Midwife and Obstetrics Unit (MOU) were asked to participate in this study. Consenting women participated in an interview where they were asked questions concerning interpersonal violence and other psychosocial constructs, such as history of childhood trauma, exposure to community violence, depressive symptoms and alcohol use. Frequency distributions and descriptive statistics were calculated for categorical and continuous variables. Multivariable logistic models were developed to control for socio-demographics and psychosocial constructs. The first model was based on report of any form of IPV over the previous 12 months, while the remaining three models investigated the disaggregated forms of IPV: physical abuse, sexual abuse and emotional abuse.

Results: Overall, the lifetime and 12-month prevalence rate for any IPV was 45% and 32%, respectively. For 12-month IPV, 32% reported general abuse, 29% physical and 20% reported being sexually abused. After adjusting for the effects of the other variables in the model, depressive symptoms, and reporting that this pregnancy was unplanned were significantly associated with the reporting of any IPV in the past 12 months.

Looking specifically at 12 months general IPV, women who had depressive symptoms were more likely to experience some form of general IPV (OR= 6.42, CI 2.51-16.41) than women not at risk. Also, women of 'coloured' race were more likely to experience general IPV than Black African respondents (OR= 1.46, 95% CI 0.64-3.34). The model exploring associations for 12-month physical IPV found women who were at risk for depression were more likely to experience physical IPV (OR= 4.42, CI 1.88-10.41) than women not at risk, while the model exploring associations for 12-month sexual IPV found that women who reported experiencing community violence were more likely to report sexual IPV than women who reported no exposure to community violence (OR= 3.85, CI 1.14-13.08).

Conclusion: This is the first study, which illustrates high prevalence rates of IPV among pregnant woman at Mitchells Plain MOU. A significant association was found between 12-month IPV and unintended pregnancy. Also, woman who are at risk for depression were found to have an increased chance of experiencing both general and physical IPV. Sexual IPV was associated with high levels of exposure to community violence. Further prospective studies in different centres are needed to address generalisability and the effect of IPV on maternal and child outcomes. Greater recognition of IPV in pregnancy could contribute to improved antenatal care, as well as enhanced policy development for appropriate intervention strategies.

Key Words:

Intimate partner violence; Interpersonal violence; Domestic violence; Abuse; Pregnancy; Antenatal; Postnatal depression and Community violence

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CHAPTER 1

INTRODUCTION

1.1 Context

Violence is a complex behavioural phenomenon which takes on many forms across a variety of contexts. Violence can have detrimental effects for those who encounter it, often resulting in bodily harm; mental, physical and emotional suffering; loss of productivity; and fatality, representing an increased burden for social and public health sectors (DeVries, 2013; Vassors, Colliers & Fazel, 2013; Wuest, et al., 2015). Violence can be found in and among all societies and cultures, affecting the lives of all involved (Isaacs & Savahl, 2014). South Africa is a country with a long history of violence, arguably rooted in systemic racism and apartheid legislation, exerted by a minority authoritarian party against the disempowered, within political, social, judicial, informal, public and domestic settings (Moffett, 2006). Though we have entered a post-apartheid period, violence is still seen to penetrate all sectors of our society and is very common. As such, it is important to recognise the broader socio-historical contexts within which violence occurs (Shefer, et al., 2008).

South Africa has high rates of violent crime (Crime Stats SA, 2016). Norman, Matzopoulos, Groenewald and Bradshaw (2007) found that violence-related injuries accounted for the highest portion of all Disability Adjusted Life Years (DALYs) in South Africa in 2010. More recent data has shown that the Western Cape has significant levels of violence within its communities (Prinsloo, et al., 2016). Cape Town is number 9 on the list for the fifty most violent countries across the world based on a homicide rate per 100 000 individuals. Notably, the cities of Durban (41st), Nelson Mandela bay (42nd) and Johannesburg (47th) all feature on this list (Leggit, 2004; Weatstone, 2016). Statistics reveal that the Western Cape province is one of the highest ranking for murders, intimate partner violence as well as assaults (Breet, Seedat & Kagee, 2016). This indicates that across the nine provinces the Western Cape has notoriously high prevalence rates of violence (South Africa Police Services, Annual Report, 2013). For the 2013/2014 annual reports, the South African Police Services (SAPS) recorded that an average of 48.3 people per every 100 000, had been murdered in the Western Cape. These rates were higher in the Eastern Cape (52.1 per 100 000) and lower in Gauteng (26.2 per 100 000). For sexual assault, the Western Cape had

an average of 134 per 100 000, compared to the Eastern Cape (149.5 per 100 000). In addition, Western Cape ranked third place, for the most arrests being made, at 255 533 (15% of the total arrest made) [South African Police Service, 2013]. According, to Crime-stats SA (2016), an average of 451 individuals were casualties of assaults every day for the period of 2015- 2016. In addition, an average of 142 sexual offences occurred each day, in total, 51 895 sexual assaults occurred during the same yearly period (South African Police Services, 2014). A significant number of people reported that they had been assaulted, with only a small difference between the Western (412.9) and Eastern Cape (414.5) observed. Notably, very few victims of violence ever report these offences to the police, as perpetrators are often known/ related to the victims, (Souverein, Ward, Visser & Burton, 2016). Furthermore, up to 30% of victims reported the perpetrator to be an intimate partner or spouse ("Crime Statistics: Fact Sheet", 2017).

Violence in its various forms has been widely studied internationally and locally. Studies have investigated violence associated with war and conflict (Cohen & Nordas, 2014; Meyer-Parlapanis, 2016); violence among youth (Nansel, et al., 2003; Coker, et al., 2014; Fedina, Howard, Wang & Murray, 2016); violence and mental illness (Nestor, 2002; Elbogen & Johnson, 2009; Howard, Dean, Moran & Khalifeh, 2016), as well as, gender-based (Stark & Ager, 2011) and interpersonal violence (IPV) (Alhabib, Nur & Jones, 2010). In South Africa, studies of violence have focused on a range of issues and yielded important and concerning results. For example, the prevalence rates of violence perpetrated by youth have been found to be significantly high, especially among men (Spencer, Haffejee, Candy & Kaseke, 2016). Souverein, Ward, Visser and Burton (2016) examined the correlation between youth perpetrators of violence and lifetime perpetration of violence and found that males were significantly higher (41.5%) perpetrators of violence and that the severity of the violent act was positively correlated with lifetime (continual) violent behaviour. Another study, investigating the prevalence of sexual assaults in South Africa, found that more than 30% of the men that were interviewed reported having raped at least one woman in their lifetime (Jewkes, Sikweyiya, Dunkle & Morrell, 2015).

South Africa has been identified to have one of the highest rates of violence against woman and children (Abrahams, Jewkes & Mathews, 2010; Crime stats SA, 2016). Though many policies have been developed to combat violence against women, such as the Domestic Violence act 116 of 1998, since violence is rooted inequality, it is not surprising that violence is used as a means by

men to dominate women (Shefer, et al., 2008). The most frequent form of violence experienced by women in South Africa is intimate partner violence [IPV] (DeVries, et al., 2013). IPV has been identified as one of the top three causes of disability-adjusted life years in the country (DALYs), and has been in the top ten causes for DALYs since 1990 (Norman et al, 2010; DeVries, et al., 2013; WHO, 2013).

Worldwide, IPV is recognised as a key mental, medical and public health problem (WHO, 2000; WHO, 2013). The WHO (2010) found that globally 30% of women will experience violence, with overall statistics revealing more than 70% of IPV abusers to be male, including close family members, and current or ex-partners (Jeanjot, Barlow & Rozenberg, 2008; Al-Nsour, Khawaja & Al-Kayyali, 2009; Gilbert, et al., 2015). While IPV is not exclusively experienced by women and may be experienced by men as well (Frieze, 2005; Steward, Ma**c**Millan & Wathen, 2013), many studies have shown that woman are more at risk for being victims of IPV than men are (Kwawukume & Kwawukume, 2001; Schulter, Paterson & Feehan, 2007; Hien & Ruglass, 2009). A study conducted by Hoque and Kader (2009) in Kwazulu-Natal, revealed that 80% of husbands and co-habiting boyfriends were perpetrators of IPV. Furthermore, women have found to be more at risk for being murdered by an intimate partner compared to male victims (Gass, Stein, Williams & Seedat, 2010). A noteworthy finding revealed by DesMarais, et al. (2012), investigated global prevalence rates of IPV among men and woman and found no significant variance for men and woman prevalence rates. They noted that one in four women and one in five men reported being victims of IPV. Women however are more likely to have serious injuries and that 25% of men contributed to IPV related homicide.

1.2 Defining IPV

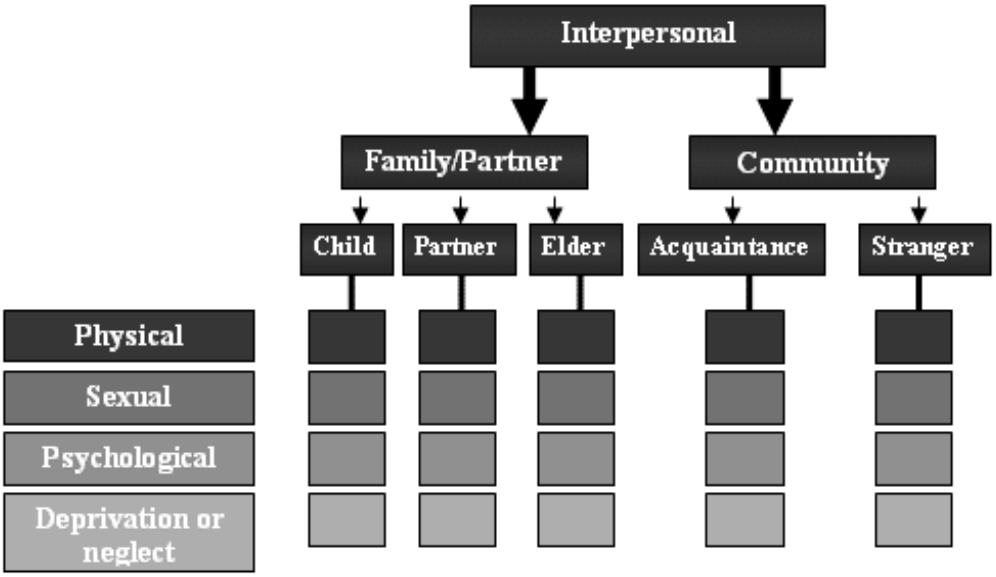
IPV is a well-documented phenomenon of behaviour in the context of human relationships. (WHO, 2005; Sarkar, 2008; Silva, Ludermir & de Araujo, 2011). IPV is commonly defined as "patterns of emotional, sexual and/or physical violence and economic intimidation by an intimate partner in conditions of coercive power" (Patel, Bhaju, Thompson & Kaslow, 2012, p.1).

According to the World Health Organisation (WHO), IPV forms part as a subtype of interpersonal violence (**see Figure 1.2.1 below**). IPV can be further categorised into four types. These include:(a) physical IPV, which includes but is not limited to acts of slapping, hitting or using

objects and/or weapons to cause bodily harm; (b) Sexual IPV, defined as any form of sexual act against the victims will, having sex with a partner although the person does not want to, being forced to perform humiliating and degrading sexual acts (Shamu, Abrahams, Temmerman & Zarowsky, 2013); and (c) Emotional IPV and controlling behaviours, which may include acts of insults, humiliations, intimidation and threatening behaviours (WHO, 2012; WHO, Violence Prevention Alliance, 2017). IPV can be perpetrated by a present or former intimate partner and is defined according to severity. All sexual forms of IPV are classified as severe as well as acts where the intention is to cause grievous bodily harm (WHO Global & Regional Estimate of Violence, 2013).

These categories indicate how intertwined violence is, impacting many spheres of a victim's life. Physical and psychological suffering as well as fear and controlling behaviour are some of the outcomes associated with experiencing IPV (Shamu, et al., 2011; Fortin, et al., 2012; Mpondo, Ruiter, van den Borne & Reddy, 2016). In addition, the consequences of IPV extend beyond physical and emotional trauma. Consequences for social domains have been found to include reduced access/attendance to education and increased rates for unemployment (Russel, Eaton & Petersen- Williams, 2013). Many studies conducted around the world have revealed risk factors associated with the experience of IPV during adulthood. Some of the key risk factors include, young age, low level of education, substance abuse, previous history of violence, childhood abuse, and smoking (Kaye, Mirembe, Bantebya, Jonhansson & Ekstrom, 2006; Shamu, Abrahams, Temmerman, Musekiwa & Zarowsky, 2011). IPV exists within every society, irrespective of age, race, gender, sexual orientation and socioeconomic background.

1.2.1 Figure 1- Typology of Violence



(http://www.who.int/violenceprevention/approach/definition/en, WHO, 2017)

Recognition for the effects of violence against women has started to increase, highlighting IPV as a pattern of conduct rather than an isolated event in the victim's experience (Charles & Perreira, 2007; Sakar, 2008: WHO 2013). IPV not only infringes upon women's rights and restricts their involvement within general society, but also significantly threatens their overall mental and physical health (Norman, Matzopoulos, Groenewald & Bradshaw, 2007; Mobasheri, Choobini, Mardanpour, Kianiz & Farsaniz, 2013).

While IPV is not solely perpetrated by men against women, women are more likely to be victims of this aggression. A systematic review examining global prevalence rates of violence against woman found that the prevalence of IPV, globally, fell between 23.8 and 40.5% (WHO, 2013). Pregnant women in particular have been recognized as a vulnerable group for experiencing elevated rates of IPV (Patel, Bhaju, Thompson and Nadine, 2012). Studies have found that abuse is likely to increase with the onset of pregnancy, usually spanning until one year post-delivery (Shah & Shah, 2010; Van Parys, Verhamme, Temmerman & Verstraelen, 2014). Therefore, this paper is focused on pregnant women as victims of IPV.

1.3 Rationale for the study

There are many reasons for investigating the prevalence and predictors of IPV amongst pregnant women in the Western Cape. First, prevalence rates of IPV have not yet been determined in this community. Prevalence rates have been found to vary across studies conducted in South Africa with overall prevalence rates remaining significantly high. Hoque, Hoque and Kader (2009) found that the prevalence rates of IPV amongst rural pregnant women were at 31%. Moreover, when examining prevalence rate of IPV among rural pregnant woman in Soweto, it was found that more than 50% of women indicated experiencing IPV in the last twelve months (Dunkel, et al., 2004). In addition, it was found that out of a sample of 1295 HIV positive females, 26.6% revealed being victims of IPV (Jewkes, et al., 2006). Understanding the frequency of IPV within this community, is essential for being able to identify needs for health and social interventions. In addition, those studies which have investigated prevalence rates in Cape Town, are relatively dated (Abraham & Jewkes, 2005).

Second, understanding the interaction between IPV and the associated factors is especially important for developing appropriate interventions aimed at these factors. IPV during pregnancy is of concern as the possible consequences pose risk to both mother and the unborn child (Taillieu & Brownridge, 2010; Mobasheri, Choobini, Mardapour, Kianiz, & Farsani, 2013). IPV during pregnancy has been associated with various negative outcomes including pregnancy-related deaths, inadequate ante-natal care, labour complications, emotional distress, depression, anxiety and harmful neonatal consequences such as low birth weight (Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; Charles & Perreira, 2007; Howard, Oram, Galley, Trevillion & Feder, 2013).

Understanding the risk factors associated with IPV in this specific population will better enable the development of socio-culturally appropriate interventions. Most of the current available intervention programmes have not been adapted for this specific context. A randomised control study which assessed the effectiveness of modified counselling sessions intervention, aimed at decreasing, IPV, tobacco use during pregnancy, depression as well as adverse neonatal outcomes found that woman who received the intervention were four times less likely to have recurring episodes of IPV. They also found that premature deliveries were less prevalent in woman who received (1.5%) the intervention compared to woman who did not (6.6%; p= 0.030) [Kiely, El-mohandes, El-Khorazaty & Gantz, 2013]. A systematic review investigating the current evidence-

based interventions for pregnant woman found that almost half of the studies reported a decrease in IPV or negative outcomes for the intervention groups, but that for most of them there were no statistical differences between the control and intervention groups, indicating less favourable outcomes associated with the interventions applied (Verhamme, Temmerman & Verstraelen, 2014).

To date there have been no studies to investigate the prevalence of IPV in Mitchell's Plain, Cape Town, South Africa, and the associations between alcohol use, depression, childhood abuse and exposure to community violence. The present study attempts to address this gap by answering the following two-pronged research question: ***what is the prevalence of IPV among women attending one antenatal clinic in the Western Cape, and what are the risk factors associated with IPV among this population?***

1.3 Aim

To determine the prevalence of IPV and the associations with known risk factors among women attending a midwife and obstetrics unit in the Western Cape.

1.4 Objectives

a. To determine the prevalence of IPV experienced by pregnant women who present for antenatal care at one Midwife and Obstetrics Unit (MOU) in the Western Cape.

b. To examine the predictors and risk factors associated with IPV amongst this population, by investigating a range of demographic variables, personal histories of childhood abuse, mental health and exposure to community violence.

1.5 Thesis Outline

Chapter 2 reviews the international and global literature on the prevalence rates and risk factors associated with IPV. Chapter 3 describes the methodology employed in the current study to gather the data to achieve the study's objectives. The results of the study are reported in Chapter 4, while Chapter 5 offers some concluding remarks, including recommendations for future research.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The previous chapter provided an overview of the research questions that this paper aims to address. The purpose of this chapter is to offer a review of the available literature regarding the prevalence rates and risk factors for IPV. Various methods were used to help locate studies for this review. These included: a) conducting literature searches on numerous academic (UCT Library) databases including: PubMed, Academic Online, Psychiatry Online, Ebscohost, Eric via Ebscohost, PsychINFO, Academic Search Premier; SAGE journals; Google Scholar and MEDLINE; b) reviewing resources and authors suggested by supervisors, peers and colleagues c) using the reference lists of other relevant studies to obtain appropriate articles. The following keywords were used: "intimate partner violence" OR "interpersonal violence"; OR "domestic violence"; AND "pregnancy"; OR "antenatal"; OR "prenatal" AND "prevalence rates"; AND "childhood trauma"; OR "alcohol abuse" OR "substance abuse" OR "depression" OR "postnatal depression". Searches were limited to scientifically sound, peer reviewed articles. Both quantitative and qualitative studies were included. Only studies published in English were included.

This chapter will start by describing a review of the international and local prevalence rates of IPV. Literature concerning the associated risk and protective factors will be also be reviewed. This will be followed by describing findings regarding the impact that IPV has on women, particularly pregnant women.

2.2 Prevalence of IPV

Many studies have investigated prevalence rates of IPV. Globally, prevalence rates of IPV range from 5 to 33% (Harling, Msisha & Subramanian, 2010; DeVries, et al, 2013). In countries, such as the United States and Canada the prevalence of IPV ranges from 22-29% (Bourey, Williams, Bernstein, & Stephenson, 2015). Alhabib, Nur & Jones (2010) conducted a systematic review for prevalence rates of IPV. In their analysis of the literature, they found that a majority of studies conducted occurred in the following countries; North America (41%) and Europe (20%). In Spain

for example, high levels of IPV are found, with overall of 32% of woman experiencing lifetime IPV (Montero, et al., 2010). A US study thoroughly investigated archival data from a domestic violence assessment centre in the USA found more than 70% of women reported experiencing IPV, specifically physical IPV (Connor-Smith, Henning, Moore & Holdford, 2011).

African countries were especially identified as having elevated rates of IPV, with an estimated prevalence range of 27- 48%, highest rates of IPV were found in Zambia (48%), and then Kenya (46.2%); (Roman & Frantz, 2013). Similar results have been found in studies from Sub-Saharan Africa; that close to 17% of couples in Malawi reported sexual IPV in their current relationship, higher levels were reported in woman (21%) compared to men [11%] (Conroy, 2014). Corresponding rates were found in men and woman from Rwanda. Overall lifetime prevalence rates for physical IPV in woman were 21.7%, whereas men were found to be only 4% (Umubyeyi, Morgen, Ntanganira, 2014).

In South Africa, IPV significantly contributes to the burden of disease for women in the country, ranked as the second highest contributor after HIV/AIDS. In a systematic review investigating the prevalence of IPV in South Africa, rates of more than 60% were reported (Joyner & Mash, 2012). The average prevalence for lifetime exposure to IPV for South Africa was found to be 25.7%. Another study conducted in Cape Town also found a very high prevalence rate for woman who experience IPV, with 85% of woman reporting some form of IPV in the past year (Zembe, et al., 2015). They also found that gender roles are significantly associated with perpetration of IPV, with more than half of men (68%) reporting that it is acceptable for a woman to be slapped or hit by a man. Another study examining IPV in the Western Cape found that 42% of men from Cape Town reported using violence as a means of resolving conflict with their partners and a further 16% reported using sexual violence against an intimate partner (Abrahams, Jewkes, Hoffman & Laubser, 2004).

Given the high prevalence rate in many countries, the WHO has come to recognise IPV as a pressing health priority, world-wide (WHO, 2013; Roman & Frantz, 2013).

2.2.1 IPV during pregnancy

While most of the literature focuses on violence against women in the general population (Katiti et al, 2016), pregnancy has been identified as a period of increased risk for exposure to IPV (WHO, 2011). Many studies have revealed high prevalence rates of IPV among pregnant woman (Hedin & Jansons, 2000; Shah & Shah, 2010; Williams, Bernstein & Stephenson, 2015). A systematic review investigating prevalence rates of IPV among pregnant woman found that approximately 30% of pregnant woman globally have experienced a form of IPV during their lifetime (WHO, 2013). Consistent with these findings, a systematic review conducted by De Vries (2013) and colleagues reviewing studies from 81 different countries found that overall prevalence rates for IPV during pregnancy for the year 2010 was also 30%.

The available research suggests that women's experiences of IPV have been found to increase during pregnancy (WHO, 2011; Alhusen, et al., 2014; Bernstein, et al., 2016). According to Khawaja, Mahfoud, Afifi and Madi (2009), IPV rates increased from 23% to 50% with the onset of pregnancy. Some studies have suggested that the risk of IPV has been shown to double during course of the pregnancy (Coker, Sanderson & Dong, 2011). A study which examined infanticidal motives of violence during pregnancy for a women's shelter in North England, revealed that of 43 women interviewed, 20 of the participants had been subjected to a form of physical violence, with the highest rates for physical abuse types being blows received on the back (75%), 70% to the face and 65% to the abdominal and face area (Graham-Kevan & Archer, 2011). It was also revealed that the overall prevalence rate for physical aggression experienced by the woman at the relevant shelter is more than 46%. Importantly, qualitative analysis revealed that these women identified with being trapped in lonely environments and manipulating intimate relationships.

It has been noted that the statistics regarding IPV among pregnant women vary from country to country with significant discrepancies highlighted between HIC and LMIC (Al-Nsour, Khawaja & Al-Kayyali, 2009; Howard, Oram, Galley, Trevillion & Feder, 2013; Devries, et al., 2013). Studies conducted in high income countries (HIC) such as the USA and UK, found that 1.5 to 4% of pregnant women will experience some form of IPV in their lifetime (Saito, Cooke, Creedy & Chaboyer, 2009; Koski, Stephenson & Koenig, 2011). Saltman and colleagues investigated the prevalence of IPV around the time of pregnancy; across 16 different HIC. They found 7.2% of their 64,994 (across the different states) respondents had experienced physical violence before

their pregnancy and 5.3% of these participants experienced some form of physical violence during their recent pregnancy (Saltman, Johnson, Gillbert & Goodwin, 2003). This suggests that IPV might decrease during pregnancy in these HICs.

In contrast, recent data from a systematic review showed that between 4 and 29% of pregnant women from low and middle income countries will experience some form of IPV (Adabi, Ghanzinour, Nojomi & Richter, 2012; Mobasheri, Choobini, Mardanpour, Kianiz & Farsani, 2013). Jackson, et al (2015) found that 16% of low-income Mexican-American participants reported experiencing IPV before and during their pregnancies, with physical intimate partner violence being the most prevalent among the women (13%).

The few systematic review studies that have investigated the prevalence of IPV in Africa generally and South Africa specifically, found that between 2 and 57% of pregnant women have experience some form of IPV in their lifetime (Shamu, Abrahams, Temmerman, Musekiwa & Zarowsky, 2011). For example, a study examining the prevalence and patterns of IPV among 1 395 women attending antenatal clinics in Soweto, found that more than 50% of those women had experienced IPV during their current pregnancy (Dunkle, et al., 2004). In addition, Joyner and Mash (2011) found that of 164 pregnant women attending rural and urban health care facilities in the Western Cape, South Africa, more than 55% of the women reported experiencing IPV throughout the pregnancy. Groves, Kagee, Maman, Moodley and Rouse (2011) identified a quarter of the women in their study (24.75%) that were experiencing at least one form of IPV during their pregnancies. Adding to this, IIika et al. (2012) established that 40% of Eastern Nigeria women were victims of IPV at some point during their life. Furthermore, a study which examined the prevalence rates of IPV amongst postnatal women in Zimbabwe, revealed that of the 2042 women interviewed, more than 60% reported experiencing some form of IPV during and after their pregnancy (Shamu, Abrahams, Zarowsky, Shefer & Temmerman, 2013).

Despite these high rates of IPV documented, Joyner and Mash (2012), found that within the South African primary healthcare sector, less than 10% of women who experience IPV are detected because of low rates of reporting/ disclosure. This means that many women do not receive the care or intervention that they might need.

Also, some researchers have identified different ways in which women from rural and low-income settings react to being exposed to IPV (Bhandari, Bullock, Anderson, Danis & Sharp, 2011). Qualitative differences in mothering skills, coping strategies and complications during labour were noted. When examining the fear of an intimate partner in the first trimester of pregnancy, Brown, McDonald and Krastev (2008) determined that from their representative sample of 1 217 pregnant women under 24 weeks, that more than 18% reported being afraid of their current intimate partner. Identifying the factors that make women more vulnerable is important to the development and design of appropriate interventions.

Even though the majority of research yields different prevalence rates for IPV, what remains certain is that IPV is enduring phenomenon which affects countless of women and families across the world. The present study seeks to add to the current literature by examining the prevalence and associated risk factors for IPV among women attending one antenatal clinic in the Western Cape. Previous studies conducted in the Western Cape have not yet explored the prevalence rates and associated risk factors of IPV within the Mitchell's Plain community. Rather, the majority of the studies have been conducted in rural rather than urban settings (Dunkle, et al., 2004; Joyner & Mash, 2012; Groves, Kagee, Maman, Moodley & Rouse, 2012).

2.3 The impact of IPV on victims

Many studies have highlighted the various outcomes associated with IPV. Though rates may vary across studies, what remains certain is the associated impact of IPV on its victims is always negative (Lagdon, Armour & Stinger, 204; Simmons, Wijma & Swahnberg, 2015; Wong & Mellor, 2014). Studies from Canada found no difference in levels of physical IPV experienced by men (28%) and woman (27%), however they did find that woman were more at risk for experiencing psychological distress than men (Fortin, et al., 2011). In addition, Patel, Bhaju, Thompson & Kaslow (2011) found that African-American woman who experience IPV have a greater risk for experiencing mental health problems such as depression, anxiety related disorders and post-traumatic stress disorder (PTSD) compared to woman who were not being abused.

A study conducted by Keygnaert, Vettenberg & Temmerman (2012) examined the rates of violence among refugees and asylum seekers in the Netherlands and Belgium and noted the following outcomes associated with IPV: (1). Psychological and emotional distress: they found

that two thirds (62%) of victims reported feelings of insecurity, depression, suicidal thoughts, social anxiety and nightmares; (2). Socio-economic consequences: 33% of respondents reported losing a job because of the violence, having no support, withdrawal from close friends, family and social activities; (3). Physical consequences: almost half of the respondents indicated that they suffered from exhaustion, weight loss, nausea and stomach problems as well as aches and pains; and lastly (4). Sexual and reproductive health consequences: just over half of the cases (56.6%) stated suffering from one or more of the following, HIV/AIDS, sexually transmitted infections (STIs), unintended pregnancies and having to terminate a pregnancy.

At primary health clinics in Spain, woman illustrated various negative outcomes associated with experiencing IPV. There were significant difference between women who were abused compared to non- abused women. Women who reported IPV, were three times more likely to report psychological distress and somatic complaints, as well as twice as likely to use medication such as sedatives or antidepressants than woman who don`t experience IPV (Montero, et al., 2010). HIC such as the USA have also found IPV to have an impact on the economic functioning, with almost 8 million days of work lost due to IPV related cases (Mondi, Palmer & Armstrong, 2013).

Corresponding studies in Rwanda similarly found that woman were twice as likely to suffer from depression, attempt suicide, or experience PTSD symptoms than men who reported experiencing violence from a partner (Umubyeyi, Mogren, Ntaganira & Krantz, 2014). A study from a Togo in Africa, discovered a significant association between IPV and recently established HIV infection and that being a victim of IPV influences help seeking behaviours. They also found that women who were HIV positive had a higher prevalence rate of IPV (63 %) than women who were HIV negative (Burgos- Soto, et al. 2014). A nationally representative sample of women and men from South Africa, found that major depressive disorder was significantly associated with being a victim of IPV (Gass, Stein, Williams & Seedat, 2011).

For pregnant women, specifically, IPV poses further threat to their physical and mental well-being. Often, IPV results in negative health outcomes including physical pain, emotional distress and anxiety as well as pregnancy- and birth-related complications (Sagrestano, Carrol, Rodriguez & Nuwayhid, 2004; Gass, Stein, Williams & Seedat, 2010). Pregnancy-related complications may include, premature labour, vaginal bleeding during pregnancy, miscarriages, neonatal deaths, etc. (OReily, 2007; Sarkar, 2008; Zlotnick, Capezza & Parker, 2011). Moreover, it has been found

that financial, social, and overall health problems may result from experiencing IPV (Akyiz, Sahiner & Bakir, 2008; Bailey, 2010; Abadi, Ghazinour, Nojomi & Richter, 2012). IPV was found to obliquely cause harm by: impacting on the mental health status of the woman, her antenatal treatment, as well as increasing alcohol and substance abuse during pregnancy (Sagrestano, Carrol, Rodriguez & Nuwayhid, 2004; WHO, 2005; Barlow & Rozenberg, 2008; Devries, et al., 2013). It was found that woman who had given birth to low birth weight babies were twice as likely to be victims of IPV than woman with normal birth weight babies (Rosen, Seng, Tolman & Mallinger, 2007).

Gao, et al. (2010) established that of 828 postnatal mothers interviewed, the prevalence for adverse outcomes after experiencing IPV were as follows: 25% started smoking, 14 % reported using alcohol and 8.5% were found to screen positive for psychological distress. Depressive and anxiety symptoms especially are noted among women (during and after pregnancy) who experience IPV (Groves, Kagee, Maman, Moodley & Rouse, 2012). Additionally, it was found that women who experience IPV during pregnancy are more likely to be victims of homicide from their intimate partners, compared to women who were not pregnant (Abrahams, Mathews, Martin, Lombard & Jewkes, 2011; Abrahams, Mathews, Martin, Lombard & Jewkes, 2013).

IPV was recognised by Graham-Kevan and Archer (2011) to be a notable contributor to both maternal and perinatal mortality as well as morbidity. Results from a case control study found that women often were victims of femicide. Of the total (307) reported cases of femicide, 70% were cases in which physical abuse had occurred in the months leading up to their deaths, by the same intimate partner who murdered them (Campbell, et al., 2003). In addition, it was found that 36% of pregnant woman in Chicago stated they had visited health care services, five or more times in the past twelve months. Moreover, it was found that these women were six times more likely to develop PTSD related to their IPV (Stampfel, Chapman & Alvarez, 2010). A noteworthy finding form Graham-Kevan & Archer (2011) revealed that 65% of woman in England reported that they had received blows the abdomen, indicating direction of anger toward the foetus.

2.4 Risk factors for IPV

To develop appropriate strategies for IPV prevention amongst pregnant women, an understanding of the associated risk and protective factors is essential. This section will describe some of the most known risk factors identified in the literature. These include, but are not limited to: a) alcohol abuse, b) mental illness; c) history of childhood abuse and d) exposure to violence within a community.

Several socio-demographic factors have been found to be associated with IPV. Women from low socio-economic backgrounds have been found to be more at risk for experiencing IPV compared to woman from higher socio-economic backgrounds (Patel, Bhaju, Thompson & Kaslow, 2011). The literature also shows that rural and low income settings are burdened by issues such as violence, substance abuse, crime, and poverty and in turn these have been found to be associated with IPV (Saltman, Johnson, Gillbert & Goodwin, 2003; Svavarsdottir, 2010).

Research findings frequently highlight the lack of access to resources (basic and supportive), or inadequate/overburdened resources available for women residing in such settings. In these contexts, IPV prevalence rates tend to be somewhat higher. For example, a study which examined the prevalence rate and risk factors for mothers in Bangladesh found a very large proportion (82%) of the woman reported experiencing IPV. In addition, it was established that 74% of woman experienced this violence before their children had been born, and during the pregnancy (Azziz-Baumgartner, 2016). These findings are similar for studies done in Africa and Asia (van Parys, Verhamme, Temmernman & Verstaelen, 2013). A longitudinal study focusing on 2050 married women revealed that a third of women who experience IPV report that arguments occur due to financial concerns (Hindin & Adair, 2002).

Other socio-demographic variables that have been found to be associated with IPV include level of education and age. One cross-sectional study of 1502 pregnant women attending health care facilities in Mpumalanga, South Africa, found that more than 55% of those women had less than a grade 12 level education and that the dominant age was between 18 and 24 years (Matseke, Peltzwe & Mlambo, 2012). In support of this, a prevalence study examining IPV during pregnancy found that 28% of six hundred pregnant women had experienced a form of domestic violence during their pregnancy (Abi, Ghazinour, Nojomi & Richter, 2012). This study found that both

higher socio-economic status and higher education levels were protective factors for women against experiencing forms of IPV.

2.4.1 Alcohol abuse

A commonly noted risk factor associated with IPV, is the harmful use of alcohol during pregnancy (WHO, 2010; Labato, Moraes, Dias & Reidenheim, 2011). Alcohol use has been associated with countless personal harms including violence and aggression; elevated rates of IPV; general familial friction as well as poor parenting styles (Stanley, 2008). A systematic review examining alcohol consumption and IPV among woman, found that longitudinal studies commonly revealed that woman who engaged in regular alcohol use reported experiencing more physical IPV than woman who drank less frequently [pooled OR= 1.27; p=0.437] (DeVries, et al., 2013). The same study found that for cross sectional studies a statistically significant association between alcohol use and victimisation of IPV was found to be reported in the literature (OR= 1.80). However, they noted that the relationship in this association is not certain. This suggests that alcohol consumption and IPV exacerbate the consequences of one another, linking alcohol use to an individual's possibility for either being a perpetrator or a victim of violence (WHO, 2006). A study examining alcohol as a potential modifier for IPV, found a significant association between physical IPV and alcohol abuse in both partners of the relationship [p= 0.012 and p= 0.017] (Labato, Moraes, Dias & Reidenheim, 2011).

The literature suggests that alcohol use strongly correlates with men being violent towards the women with whom they are in relationships (Leonard & Eiden, 2007; Abrahams, Mathews, Martin, Lombard & Jewkes, 2009; Abadi, Ghazinour, Nojomi & Richter, 2012; Devries, et al., 2013). It has been argued that alcohol use increases the risk of experiencing IPV as it affects both cognitive and physical functioning, often reducing the ability of self-control and increasing the likeliness of violent altercations (WHO, 2006). Alcohol abuse has been found to be a common variable for the occurrence of IPV; alcohol is therefore seen to be a modifier for abuse in relationships, resulting in increased risk for experiencing IPV (Lobato, Moraes, Dias & Reichenheim, 2011).

In contrast, Leonard and Eiden (2007) found that women report a decrease in alcohol consumption during pregnancy, however consumption was found to increase during the postnatal period.

Stanley (2008) found that pregnant women who experience IPV could use alcohol and substances as an attempt to cover up their distress. Adverse childhood experiences have also been identified as a risk for alcohol-related problems during adulthood, suggesting that both childhood abuse and experience of IPV exacerbate the use of alcohol by the victim (Timko, Sutkowi, Pavao & Kimerling, 2008).

Alcohol consumption is noted to be high amongst South Africans; especially in the Western Cape where rates of alcohol abuse exceed 20% (Herman, Stein, Seedat, Heeringa, Moomal & Williams, 2009; Myers, Stein, Mtukushe & Sorshdal, 2012). Alcohol use has been associated with increased risk of perpetrating acts of violence, increased risk for being a victim of IPV; increased risk for exposure to IPV as well as increased risk of resorting to alcohol as a means of coping with IPV (WHO, 2010; Simonelli, Pasqual & De Palo, 2014). Notably, disability estimates associated with alcohol use, showed that alcohol use disorder accounted for 44 % of disabilities, IPV for 23 % and Foetal Alcohol Syndrome (FAS) for 18 % , suggesting an important link between alcohol use, IPV and disability (Schneider, et al., 2007). Developing an understanding of the association between alcohol consumption and IPV is particularly fundamental in South Africa, as IPV is documented as one of the primary causes of death in the country (Mathews, Abrahams, Jewkes, Martin & Lombard, 2009).

A study conducted by Mathews, Abrahams, Martin and Lombard (2009) revealed that two out of three South African women had consumed alcohol prior to her death due to IPV related homicide, indicating that women who experience IPV are at risk for abusing substances and alcohol. At the same time, many studies have revealed increased rates of women reporting that their partner consumed alcohol prior to the assault (Abrahams, Jewkes, Hoffman & Laubser, 2004; Stanely, 2008; Eaton, Kalichman, Sikkema, Skinner, Watt, Pieterse, & Piptan, 2012; Abrahams, Mathews, Martin, Lombard & Jewkes, 2013).

2.4.2 Childhood Trauma and IPV

As demonstrated in the literature review, IPV is not an isolated occurrence, but part of an interaction between social, personal, emotional and psychological factors (WHO, 2010; WHO, 2013). One of the social factors commonly identified as a risk factor for IPV is being exposed to

or witnessing violence as a child (Norman, et al., 2010; Capaldi, Knooble, Shortt & Kim, 2012; Moore, Easton & Mcmahon, 2012; Shamu et al., 2016).

A notable association between childhood abuse and IPV has been identified, demonstrating that women who have experienced abuse during their childhoods are more likely to experience IPV during their adult years, compared to women who had not experienced abuse during childhood (Whitfield, Anda, Dube & Feletti, 2003; Widom, Czaja & Dutton, 2008; Patel, Bhaju, Thompson & Kaslow, 2012). Dunkle, et al. (2004) found that childhood sexual violence was established as a major risk factor for experiencing IPV in adulthood. Outcomes of childhood abuse have predominantly centred on victims re-experiencing abuse in their adulthood, either by becoming perpetrators of violence themselves, or by becoming victims of violence again (Omduff, Kelsey, OLeary, 2001; Widom, Czaja, & Dutton, 2008).

According to Whitfield, Anda, Dube and Felitti (2003) the risk for experiencing IPV amongst adult women escalates with the frequency of the abuse experienced childhood. It has been postulated that the experience of childhood abuse serves as a model for children, thus teaching them to behave and act violently towards others (Ben-Davids & Goldberg, 2008).

Whitfield, Anda, Dube and Felitti (2003) found that for women, childhood abuse increased the risk of experiencing IPV in adulthood; moreover, for men a significant association between childhood abuse and perpetrating IPV in adulthood was identified. This is especially the case for childhood sexual and physical abuse (Widom, Czaja & Dutton, 2008; Howard, Dean, Moran & Khalifeh, 2016). In addition, a retrospective study investigating childhood factors associated with IPV found that witnessing violence as a child was strongly associated with perpetrating IPV in adulthood, risk ratio (RR)= 2.6 (Gilman, Fitzmaurice, Decker & Koenen, 2010). A study examining risk factors associated with IPV in pregnant woman in Peru found that 61.1% of women reported experiencing a form of IPV and of these, a total of 37.3% reported that they had experienced physical abuse during their childhood (Barrios, et al., 2014). Barrios and colleagues (2014) also demonstrated that women with a history of childhood abuse and neglect were twice as likely to experience IPV in adulthood (OR= 2.20; 95%CI; 1.72-2.83).

In addition, a study from South Africa found that childhood trauma is a predictor for antennal depression (Alhusen, Ray, Sharps, & Bullock, 2015);Choi, et al., 2015Contradicting (Hartley et

al., 2011)this finding, was a study examining the associations between IPV and emotional distress among pregnant woman in Durban. This study found no association with childhood trauma and IPV, they also revealed a small prevalence rate of 5 % for childhood abuse in the sample of woman (Groves, et al. 2012).

Though many studies have investigated childhood abuse and its association with subsequent perpetration or experience of violence, most of these studies have focused on the general population (Abrahams, Jewkes, Hoffman & Laubsher, 2004; Tajima, Herrenkohl, Moylan & Derr, 2011). A current gap in the literature identified, is a lack of studies investigating experience of childhood abuse and its association with IPV victimization among pregnant woman. This study hopes to address this gap.

2.4.3 Community violence and IPV

Violence should not be viewed as an isolated event, but rather one that is manifested and fuelled by greater influences, one of which is the community in which one resides (Hamberger, 2015). While violence occurs across all socio-cultural contexts, poorer communities may be more at risk. Mental health studies commonly ascribe the motives of violence to the individual or genetic pathology (King, 2012). Though many studies support this view point (Niehoff, 2013; Beaver, Nedelec, Schwartz & Conolly, 2014; Wasserman, 2014) mitigating environmental factors are also considered as part of the causal factors associated with violence (Chen, Voisin & Jacobson, 2016; Coid, Kallis, Doyle, Shaw & Ullrich, 2015).

Frustrations associated with low levels of socio-economic opportunities and high levels of unemployment, may be implicated in high levels of crime and violence, as well as high rates of alcohol and substance abuse sometimes found in poorer communities (Raghavan, Mennerich, Sexton & James, 2006; Beyer, Wallis & Hamberger, 2015). Low-income communities especially face problems with gangsterism and violent crimes. It has been reported that high rates of exposure to community violence often results in the notion that violence is acceptable (Abrahams & Jewkes, 2005). Of course, individuals living in areas where frequent and elevated rates of violence exist are themselves at risk for being victims of violent acts (Gaylord-Harden, Dickson & Pierre, 2016). In support of this, Shields, Nadasen and Pierce (2013) found elevated rates of exposure to violence within communities, especially witnessing violence in schools and within residential areas, to

confer the risk of experiencing IPV. Raghavan, Mennerich, Sexton & James (2006) illustrated this further when 50% of their respondents from various low income setting across the USA, indicated that they had witnessed some form of violence within their community in the past twelve months. Of those, one third revealed having been a victim of IPV in the past six months (Raghavan, Mennerich, Sexton & James, 2006).

Communities in which are found high levels of unemployment, high levels of crime and low levels of education, families are more at risk for experiencing IPV (Dahlberg, Ikedaz & Kresnow, 2004; Mobasheri, Choobini, Mardanpour, Kianiz & Asadi, 2013). Li, et al. (2010) argues that these factors add to the frustration experienced by perpetrators in communities where violence is condoned, making them more likely to become a perpetrator of IPV. Bogat, et al. (2005) argue that communities form their own social norms in which many structural differences exist, especially in the case of gender inequality. Al-Nsour and Khawaja (2011) found that the justification or acceptance of violence and abuse within a community may function as a catalyst for IPV.

In many communities with high levels of IPV, women are viewed as inferior compared to men (Mobasheri, Choobini, Mardanpour, Kianiz & Asadi, 2013). In some communities, violence is seen as an acceptable way of punishing women (Dill & Ozer, 2015; Gaylord-harden, Dickson & Pierre, 2015). These types of community norms are relevant to understanding the function of IPV in the family and in intimate relationships (Kaye, Mirembe, Ekstrom, bantebya & Johansson, 2005; Bogat, et al., 2005). It has been argued that addressing the social norms that condone violence against women is an area that requires urgent attention (Shamu, Abrahams, Zarowsky, Shefer & Temmerman, 2013).

Furthermore, it has been suggested that the socio-cultural characteristics of a community determine the response of women to IPV assault and the resources that she may seek out (Eisenman, et al., 2009). Social support has been identified as a protective factor against the adverse outcomes of IPV, and is also thought to contribute to a better quality of life experienced by survivors of IPV (Bauman, Haaga, Kaltman & Dutton, 2012). However, very little research has investigated the function that social and community values have on IPV, general violence, and help-seeking behaviours. As such, little is known about the socio-cultural factors and circumstances that surround IPV (Eisenman, et al., 2009), making it important to examine the association between characteristics of communities and IPV.

Most of the current literature focuses on violent acts committed between individuals (intimate partners, siblings, relatives, friends or strangers (Cpaldi, Knoble, Shortt & Hyoun, 2012). However, few studies have properly investigated the relationship between IPV and high levels of violence in the community.

2.4.4 Mental Health and IPV

Not surprisingly, mental health problems have been shown to be highly correlated with experiences of IPV. These include psychological suffering and emotional distress; as well as mental health conditions including depression, anxiety and PTSD (Fortin, et al., 2012; Umubyeyi, Mogren, Ntaganira & Krantz, 2014). Koen, et al, (2015) explored the risk factors associated with trauma and PTSD. They found that of 544 women interviewed, roughly two thirds reported experiencing lifetime IPV. Furthermore, Howard, et al. (2010) determined in a systematic review, a wide range of prevalence rates (34%- 92%) for IPV among female psychiatric patients.

Psychological stress was found to be present in 20% of the women for lifetime IPV Roth (2015) found that woman who reported higher rates of IPV where more at risk for developing depression than woman who experience lower rates of IPV. Agu`ir, et al. (2012) also found that poor psychological outcomes were associated with recurrent exposure to IPV. Rao, Horton and Raguraam (2012) noted significant prevalence levels off major depressive episodes in woman who were abused, they estimated that 75% of the woman sampled had symptoms for Major Depressive Disorder. A study conducted by Jackson, et al. (2015) revealed that for their sample of pregnant woman, a history of IPV is significantly associated with experience of depression (35.82. $p > .001$).

Recently, Woollett and Hatcher (2016) found that in South Africa, symptoms of depression increase among individuals who experienced elevated rates of exposure to violence in both domestic and community settings, supporting the argument that violence has an impact on the mental functioning of an individual (Iverson, 2015).

Pregnant women are possibly additionally vulnerable as evidenced by the high prevalence rates of mental health problems that occur during this time (Holden, McKenzie, Pruitt, Aaron, & Hall, 2012). In South Africa, the prevalence of antenatal depression has been shown to range between 22% and 37% (Rochat, Tomlinson, Bärnighausen, Newell, & Stein, 2011). This is likely to be compounded by the experience of IPV during this time. One qualitative study investigating

women's experiences of postnatal depression found that some of the respondents identified IPV as the precipitant for the depressive symptoms they were experiencing. Statements such as "it really affects me mentally" were common descriptions of their experiences (Kathree, Selohilwe, Bhana & Petersen, 2014). Adding to this, a study conducted by Heyningen, et al. (2016) found that woman who experience IPV victimisation were almost twice as likely to develop a major depressive episode (MDE) compared to woman who reported no IPV.

Symptoms of depression were investigated among 95 women attending antenatal appointments it was noted that aggressive and controlling behaviours from partners were strongly associated with increased symptoms of depression in the mothers (Martin, et al., 2006; WHO, 2010). In what may represent a vicious cycle, several studies have found that people with mental illness have an increased risk of becoming victims of abuse and ill-treatment (Elobogen & Jonhson, 2009; Ullrich, 2015). For example, Beydoun, et al. (2012) found that women with major depressive disorder (MDD) were twice as likely to experience IPV than woman without MDD.

2.5 Concluding paragraph

As mentioned in chapter two, at the present time, it is known that IPV may affect everyone, however women appear to be more at risk for being victims of IPV. The impact thereof is always negative, may last a lifetime and often creates a perpetuating cycle of violence for all involved. Prevalence rates of IPV are generally high across contexts, but seem especially elevated in low and middle income countries (LMIC) where it is a pressing public and mental health problem that needs attention. Of concern is that prevalence rates of IPV during pregnancy also appear to be elevated, this is especially the case for South Africa (WHO, 2013; Shamu, et al., 2016).

Where risk factors are concerned; while in some instances, directional links between risk factors and IPV are evident (for example, a history of childhood abuse), the association between other risk factors and IPV is less clear. For example, substance abuse and depression may increase the risk for IPV but may well also be as a result of IPV.

Very little is known about IPV among pregnant women attending antenatal clinics in the Western Cape. Additionally, few studies have examined the association between childhood abuse, alcohol abuse and exposure to violence within the community. The present study attempts to address this

gap by exploring these associations among women attending one Midwife Obstetric Unit in Mitchells Plain, Cape Town, South Africa.

CHAPTER 3

METHODS

3.1 Overview of Chapter

This section will outline the research model guiding the study's methodology. A brief overview of the context of the study describing the setting, population, study procedure and the measures used are defined. Furthermore, a description of the data collection and data analysis methods are described. To conclude this section, the ethical considerations are stipulated.

3.2 Study Design

This study followed a cross-sectional quantitative research approach. Quantitative research aims to determine the relationship between two variables (Hopkins, 2008). It was appropriate to use a quantitative approach in the current study as it aimed to determine the relationship between IPV and pregnant woman as well as the relationship between IPV and possible risk factors for this population.

3.2.1 Setting

This study was conducted at Mitchell`s Plain MOU, a primary level maternity facility that offers pregnant women antenatal care throughout the pregnancy, as well as HIV testing and counselling. The facility also has a labour ward section for deliveries as well as post-natal care. Data collected by the researcher in preparation for this study indicated that the Mitchell's Plain MOU has approximately 600 new pregnancy bookings each month, on average.

(http://mitchellsplaindentist.co.za/about-mitchells-plain/, 2017).

3.2.2 Sample Size

It was estimated that this study will have 15 women who experience IPV and 135 without. Prior data has indicated that the probability of exposure to alcohol is 0.25. If the true odds ratio for IPV in alcohol abusers relative to non-abusers is 4, we will be able to reject the null hypothesis that this odds ratio equals 1 with probability (power) .630. The significance level was set at $p<0.05$. In total 150 pregnant women were interviewed.

3.2.3 Participants

A convenience sample of a hundred and fifty pregnant women (n= 150) attending antenatal appointments at the Mitchell's Plain MOU were asked to participate in this study. The sample of the ethically approved project involves a physically and potentially psychological vulnerable group.

Inclusion criteria for the study were as follows:

- Participants who were 18 years or older.
- Participants who were pregnant (any term during pregnancy)
- Participants who were patients at the MOU and in possession of a folder number, to minimise treatment/ referral variables.
- Participants who were accomplished and willing to participate in an interview in English or Afrikaans

3.2.4 Study Procedure

Potential participants were approached by the researcher in the collective waiting area of the MOU. The consent forms were disseminated to women in the waiting room, informing potential participants about the study prior to recruitment. Every woman received a copy of the consent form (in either English or Afrikaans – women were given the preference). An announcement was made out loud to the women in the waiting room, explaining the nature, purpose and requirements of the study, covering all the main points of the consent form. All woman in the waiting area were invited to participate in the study. The researcher allowed time for review, after which the women had the opportunity to decide on participation.

The women were given the opportunity to ask any questions they might have, in private. Once the researcher explained the study to the women, she asked that any woman willing to participate, approach her at the designated office during the day. Those who were willing to participate, after consideration, casually approached the researcher in the designated office, where they completed a written consent form, agreeing to participate in the study. The researcher scheduled the interview sessions to coincide with the participant's routine appointments as the MOU.

Prior to the interview, each participant was again informed about the confidentiality and anonymity concerning their involvement in the study, there was no negative consequences in cases of refusal. Participation was voluntary, as will be the decision to withdraw from the study at any stage.

Each participant signed the consent form, prior to the commencement of the interview, which was held in a private location and lasted approximately 45 minutes per participant (see appendix A-D for the questionnaires). The questionnaires were read aloud to each participant and were made available in both English and Afrikaans (due to budgetary constraints, the research could only be conducted in the languages in which the researcher is proficient, namely, English and Afrikaans). The questionnaires were administered by an experienced and trained registered trauma counsellor (researcher). Participants each received a R30 Pick `n Pay voucher as compensation for their time and effort to participate in the study. Data was collected daily from November to December 2015.

3.2.5 Measures

In order to fulfil the study's objectives, the following measures were used: (**See Appendix I- XIV**)

Socio-demographics Questionnaire: Information was collected regarding participant's race, age, level of education, current employment status, marital status, whether the pregnancy was planned or unplanned, the number of previous pregnancies and; pregnancy gestation.

The Edinburgh Postnatal Depression Scale (EPDS), (Cox, Holden, & Sagovsky, 1987). This is one of the most common and widely used instruments that screens for both ante- and postnatal depressive symptoms. Reliable psychometric properties have been illustrated in multiple validation studies (Gil- Gonzalez, 2007; Shrestha et al., 2016). The EPDS was designed to detect depressive symptoms in postnatal woman, detecting symptoms featured in the last seven day. Items are scored according to a frequency scale ranging from 0 to 3. High scores are indicative of severe

symptoms, the threshold is 13 (Hartley et al., 2015). The EPDS is commonly used in low and middle income countries (Akena et al., 2012). It includes questions such as **"**I have been so unhappy that I have been crying". This measure will assist in establishing the way in which depression and anxiety may moderate the relationship between IPV and other risk factors**.**

WHO Interpersonal Violence Questionnaire (IPVQ*)*: [Jewkes, et al., (2006)] is a survey questionnaire used to screen for experiences of past and current of intimate partner violence. It assesses for general (emotional abuse and controlling behaviour), physical and sexual abuse subscales. Questions such as "Have you ever been hit, slapped, kicked or otherwise physically hurt by your current or previous intimate partner?" will assist in establishing levels of IPV in this population. Though this questionnaire has been used it has not been validated for the use in South Africa, it has been used in certain local studies, yielding good results for reliability rates (Koen et al., 2015).

Childhood Trauma Questionnaire (CTQ): (Bernstein et al., 1994): The Childhood Trauma Questionnaire is a 28-item self-report inventory that provides brief, reliable, and valid screening for histories of abuse and neglect. This instrument follows a five-factor format, enquiring about five different types of maltreatment - emotional, physical, and sexual abuse, and emotional and physical neglect. This item has been validated in both clinical and community settings and has been translated into several languages (Patel,Bhaju, Thompson, & Kaslow, 2012). Studies have found an internal consistency coefficient close to .80, which indicates good reliability for responses over a period of time, as the scale screens for abuse and neglect while the person 'was growing up' (Hernadez et al., 2013; Grassi-Oliveria, 2014).

Alcohol Use Disorder Identification Test (AUDIT): Developed by the WHO this questionnaire is used as a simple measure which screens for hazardous and harmful patterns of alcohol consumption. The AUDIT was developed in 1989 and subsequently updated in 1992 (WHO, 2001). This measure includes questions such as: "How often do you have a drink containing alcohol? How often during the last year have you found that you were not able to stop drinking once you started?" A systematic review on the psychometric properties of the AUDIT, found a great performance rates for the tool, across a variety of settings for the 47 studies analysed (Shrestha et al., 2016). Studies have found it to be reliable and effective tool to detect harmful alcohol consumption behaviours (Pitpitan et al., 2013; Sabri et al., 2014).

Exposure to Community Violence Questionnaire (World Health Organisation, 2000): This measure was adapted from Children's Exposure Too Community Violence Questionnaire (Richters & Martinez, 1990). The frequency of exposure to violence (through visual and auditable senses) is measured by this item. It determines the incidence of violence in the home and in the general neighbourhood. This includes questions such as: "Have you seen someone being beaten up? Have you seen a gun in your home?" This item asks respondents to specify how frequently they have heard or saw certain activities pertaining to violence in and around their homes and neighbourhood. This measure has not been validated in clinical settings (Beyer, Wallis, & Hamberger, 2015).

3.2.6 Data-analysis

The first aim of the study was to determine the prevalence rate of IPV among pregnant woman. To determine this rate, quantitative analyses, was conducted using the most recent version of SPSS. Frequency distributions and descriptive statistics (means, medians) were calculated for categorical and continuous variables. The unadjusted associations between IPV as the dependent variable, and participant demographic characteristics, history of childhood abuse, self-report alcohol abuse, and perception of community violence as independent variables, were analysed. Statistical significance was based on 2-sided tests and set at a = 0.05.

The second aim of the study was to determine associated risk factors for IPV. To achieve this aim, multivariate logistic models were developed to control for demographics and socioeconomic variables (including gender, age, race, and marital status), alcohol abuse, community violence and childhood trauma. The first model will be based on whether any IPV occurred, while the remaining three models investigated IPV for physical abuse, sexual abuse and emotional abuse. The results of the regression models are reported as odds ratios (ORs) with 95% confidence intervals (CIs).

3.2.7 Ethical Considerations

Before the study was conducted, the Faculty of Health Sciences Research Ethics Committee (HREC) at the University of Cape Town granted ethical approval for this study (266/2014). Permission to conduct the study at the MOU was obtained from the Western Cape Department of Health, as well as the facility management. The study adhered to the principles set out in the declaration of Helsinki (2013).

Potential Benefits and Harms of the study- In this study, no severe harms were foreseen. As such, no individual suffered exposure or harm. It is recognised that the nature of this study may elicit distressing emotional reactions. In such cases the participant were referred to the relevant health care worker, such as intern counsellors and the social worker locateed. Six B.Psych interns working at the community health centre (located on the same property as the MOU) were available daily for referrals; the social worker was also located in the same building and available on request. The researcher could refer to both the social worker and interns. Furthermore, the study's co-supervisor is a registered Clinical Psychologist who was available to provide support and containment to participants where necessary. From this study, it is hoped that further information may contribute to the planning of mental health services for pregnant women attending antenatal care.

Potential benefits for each participant included a R30 Pick `n Pay voucher as part of compensation for the time and effort the participant offered to part-take in the study.

Informed consent- All participants were provided with a consent form which describes the scope and aims of this study. The principle investigator explained any other issues as they arose. Those who decided not to take part in this study, were not obliged to do so and did not have any services withheld from them.

Confidentiality- All questionnaires were anonymous. Completed forms were stored in a locked drawer in an office. Once captured data was stored on a password protected folder on the researcher laptop. Any written or verbal reports or presentations of this information retained the patients' anonymity. The *anonymity* of each participant was accomplished by providing each participant with a participant code. This code was indicated on the consent and questionnaire forms of the participants prior to the interview. Confidentiality was safeguarded, given that only the researcher had access to the obtained data.

CHAPTER 4

RESULTS

4.1 Overview of Chapter

The previous chapter focused on outlining the methodology section of this dissertation. The current chapter focuses on providing the results. The first section will focus on describing the socio-demographics information and pregnancy related characteristics of the sample. It then moves onto presenting the unadjusted associations between IPV as the dependent variable, and participant demographic characteristics, history of childhood abuse, self-report alcohol abuse, and perception of community violence as independent variables. Four logistic regression models are presented. This includes a model predicting any 12 month IPV, followed by general, physical and sexual separately.

4.2 Socio-demographic, pregnancy related and psychosocial characteristics of the sample

Approximately 1/3 of the women who were approached to participate in the study, agreed to participate and provided informed consent. A total of 150 women were recruited. Of these women, a majority reported being single [that is having no intimate partner at the time of the interview] (n=101,67.3%), unemployed (n=93, 62%) and were between the ages of 18 and 30 years old (n=103, 68.7%). Many of the respondents had completed high school (n=79, 52.7%), however only 57 (38%) reported being employed. Respondents reported that many of them indicated that their current pregnancy was unplanned (n=115,76.7%). Noticeably of the 115 participants whom indicated that their pregnancies were unplanned only 32 (65.3%) specified being in an intimate relationship. More than half of the participants, (n=83, 55.3%) reported that they were in their second trimester of pregnancy (week 13-28). Most women reported that this was not their first child, the average number of live children was 1.3 (SD= 1.4). Only 22.7% (n=27) of the participants revealed that they had suffered a miscarriage (life time prevalence). Respondents reported high levels of childhood trauma (n= 123, 82%) and witnessing community violence (n=94, 62.7). 38.7% and 25.3% met criteria for depressive symptoms and alcohol misuse respectively. There were no significant differences between being single or in an intimate

relationship on any of these socio-demographic pregnancy related variables. (p> 0.05). See table 1 below.

Table 1: Socio-demographic, pregnancy related and psychosocial characteristics of sample

	Total (N=150)	**Single (N=101)**	**In an intimate relationship (N=49)**	***p*-value**
	N (%)	N (%)	N (%)	
Age				
18-30	103 (68.7)	74 (73.3)	29 (59.2)	0.08
31- and older	47 (31.3)	27(26.7)	20 (40.8)	
Race				
Black	67 (44.7)	50 (49.5)	17 (34.7)	0.07
Coloured	81 (54.0)	49 (48.5)	32 (65.3)	
White	2 (1.3)	2 (2.0)	0 (0.0)	
Employment Status				
Employed	57 (38.0)	36 (35.6)	21 (42.9)	0.31
Unemployed	93 (62.0)	65 (64.4)	28 (57.1)	
Education				
Did not complete high school	71 (47.3)	50 (49.5)	21 (42.9)	0.44
Completed high school	79 (52.7)	51 (50.5)	28 (57.1)	
Pregnancy Intended				
Planned pregnancy	35 (23.3)	18 (17.8)	17 (34.7)	0.02
Unintended pregnancy	115 (76.7)	83 (82.2)	32 (65.3)	
Gravidity (m, sd)	2.5 (1.6)	2.3 (1.4)	3 (1.7)	0.01
Parity (m, sd)	1.3 (1.4)	1.1 (1.3)	1.7 (1.5)	0.11
Previous miscarriage				
Yes	34 (22.7)	20 (19.8)	14 (28.6)	0.23
No	116 (77.3)	81 (80.2)	35 (71.4)	
Pregnancy Gestation				
Week 3-12	48 (32.0)	29 (28.7)	19 (38.8)	0.20
Week 13-28	83 (55.3)	61 (60.4)	22 (44.9)	
Week 29- 40 and more	19 (12.7)	11 (10.9)	8 (16.3)	
Mental Health				
High Risk Depression	58 (38.7)	44 (43.6)	14 (28.6)	0.07
Low Risk Depression	91 (61.3)	57 (56.4)	35 (71.4)	
Alcohol Use				
Low risk drinker	112 (74.7)	68 (67.3)	44 (89.8)	0.07
High risk drinker	38 (25.3)	33(32.7)	5 (10.2)	
Childhood Trauma				
No childhood trauma	27 (18.0)	17 (16.8)	10 (20.4)	0.11
Yes, childhood trauma	123 (82.0)	84 (83.2)	39 (79.6)	
Community Violence				
Low community violence	56 (37.3)	33 (34.7)	28 (57.1)	0.66

High community violence	94 (62.7)	66 (65.3)	21 (42.9)	

4.3 Prevalence of IPV among pregnant woman attending MOU

The prevalence rates of IPV during pregnancy can be seen in Table 2. Overall, the rate for IPV victimisation across participant's lifetime was 44.7%. Physical violence was the most common form of abuse experienced in the women's lifetime (n=70, 46.7%), followed by general violence (n=66, 44%) and sexual violence (n= 24.7%). Most types of IPV victimisation were reported to occur during the second trimester of pregnancy (N= 39, 58.2%). [See table 4 below.] It was noted that nearly 80% of the total population reported that they had never (in their lifetime) opened a police case for assault.

For the 12-month prevalence of IPV, approximately one- third (n=67, 44.7%) of the participants described experiencing any IPV within the past twelve months. Like the lifetime prevalence, physical violence was the most common form of abuse experienced in the previous 12 months (n= 70, 46.7%) followed by general violence (n= 66, 44.0%) and sexual violence (n=37, 24.7). Of those participants whom indicated experiencing sexual violence in the past twelve months, 20% reported perpetrations from intimate partners. No significant differences are noted for prevalence rates between single woman and woman in intimate partner relationships (p>0.05). See table 2 below.

Table 2: Overall Prevalence Rates for IPV (Lifetime vs 12 months)

	Total (N=150)	**Single (N=101)**	**In an intimate relationship (N=49)**	***p*-value**
	N, %	N, %	N, %	
Any IPV lifetime				
Yes	66 (44.7)	48(47.5)	11(22.4)	0.88
No	84 (56.0)	53 (52.5)	38(77.6)	
Any IPV 12 month				
Yes	67 (44.7)	48 (47.5)	19 (38.8)	0.31
No	83 (55.3)	53 (52.5)	30 (61.2)	

12 month IPV				
General Abuse				
Yes	48 (32.0)	34 (33.7)	14 (28.6)	0.53
No	102 (68.0)	67 (66.3)	35(71.4)	
Physical Abuse				
Yes	44 (29.3)	33 (32.7)	11(22.4)	0.2
No	106 (70.7)	68 (67.3)	38(77.6)	
Sexual Abuse				
Yes	30 (20.0)	20 (19.8)	10(20.4)	0.93
No	120 (80.0)	81 (80.2)	39(79.6)	
Police Case Ever Opened for Assault				
Yes	31 (20.7)	23 (22.8)	8 (16.3)	0.36
No	119 (79.3)	78 (77.2)	41 (83.7)	
Any IPV Lifetime				
General Abuse				
Yes	66 (44.0)	44 (43.6)	22 (44.9)	0.88
No	84 (56.0)	57 (56.4)	27 (55.1)	
Physical Abuse				
Yes	70(46.7)	44 (43.6)	26 (53.1)	0.3
No	80 (53.3)	57 (56.4)	23 (46.9)	
Sexual Abuse				
Yes	37 (24.7)	22 (21.8)	15 (30.6)	0.31
No	113 (75.3)	79 (78.2)	34 (69.4)	

4.4 Results for Any IPV in past 12 months and associated variables

The unadjusted and adjusted associations of participant characteristics on the experience of any 12 month IPV are displayed in Table 4. After adjusting for the effects of the other variables in the model, having depressive symptoms (OR= 6.56, 95% CI 2.70-15.97), and reporting that this pregnancy was unplanned (OR = 3.36, 95% CI 1.21-9.38) were significantly associated with the reporting any IPV in the past 12 months. See table 4 below.

Table 3: Any IPV in Past 12 months and associated variables

	% Yes	% No	Unadjusted OR (95% CI)	Adjusted OR (95%CI)
Age				
18-30	52 (77.6)	51 (61.4)	1.00	1.00
31- and older	15 (22.4)	32 (38.6)	0.46 (0.22- 0.95)	0.41 (0.14- 1.19)
Race				
Black	28 (41.8)	39 (47.0)	1.00	1.00
Coloured	39 (58.2)	44 (53.0)	1.29 (0.68- 2.48)	1.46 (0.64-3.34)
Employment Status				
Employed	20 (29.9)	37 (44.6)	1.00	1.00
Unemployed	47 (70.1)	46 (55.4)	1.90 (0.96-3.73)	1.24 (0.53-2.90)
Education				
Did not complete high school	31 (46.3)	40 (48.2)	1.00	1.00
Completed high school	36 (53.7)	43 (51.8)	1.09 (0.57-2.06)	1.50 (0.65-3.46)
Pregnancy Intended				
Planned pregnancy	8 (11.9)	27 (32.5)	1.00	1.00
Unintended pregnancy	59 (88.1)	56 (67.5)	3.56 (1.50-8.48)	3.36 (1.21-9.38)
Miscarriage				
Yes	15 (22.4)	19 (22.9)	1.00	1.00
No	52 (77.6)	64 (77.1)	1.03 (0.48-2.22)	0.33 (0.08-1.41)
Pregnancy Gestation				
Week 3-12	17 (25.4)	31 (37.3)	1.00	1.00
Week 13-28	39 (58.2)	44 (53.0)	1.61 (0.78-3.36)	1.90 (0.78-4.62)
Week 29- 40 and more	11 (16.4)	8 (9.6)	2.51 (0.85-7.43)	2.70 (0.71-10.24)
Mental Health				
Low Depression	27 (40.3)	65 (78.3)	1.00	1.00
High Depression	40 (59.7)	18 (21.7)	5.35 (2.62-10.93)	6.56 (2.70-15.97)
Alcohol Use				
Low risk drinker	47 (70.1)	65 (78.3)	1.00	1.00
High risk drinker	20 (29.9)	18 (21.7)	1.54 (0.73- 3.22)	0.70 (0.28-1.76)
Childhood Trauma				
No childhood trauma	14 (20.9)	13 (15.7)	1.00	1.00
Yes, childhood trauma	40 (59.7)	70 (84.3)	0.70 (0.31-1.62)	1.30 (0.46-3.71)
Community Violence				
Low community violence	50 (74.6)	44 (53.0)	1.00	1.00
High community violence	17 (25.4)	39 (47.0)	2.61 (1.30-5.25)	1.45 (0.61- 3.43)

4.5 General IPV in the past 12 months

Investigations into the unadjusted and adjusted associations between participant characteristics and the experience of general IPV in the past 12 months are reported in table 5. After adjusting for the effects of other variables, women who were at risk for depression were more likely to experience some form of general IPV (OR= 6.42, CI 2.51-16.41) than women not at risk. Also, women of coloured race were more likely to experience IPV than Black African respondents (OR= 1.46, 95% CI 0.64-3.34).

Table 4: General IPV in the past 12 months

	% Yes	% No	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Age				
18-30	37 (77.1)	66 (64.7)	1.00	1.00
31- and older	11 (22.9)	36 (35.3)	0.55 (0.25-1.20)	0.31 (0.09-1.07)
Race				
Black	14 (29.2)	53 (52.0)	1.00	1.00
Coloured	34 (70.8)	47 (64.1)	2.74 (1.31- 5.72)	3.79 (1.448- 9.75)
Employment Status				
Employed	13 (27.1)	44 (43.1)	1.00	1.00
Unemployed	35 (72.9)	58 (56.9)	2.04 (0.97- 4.31)	1.23 (0.48-3.12)
Education				
Did not complete high school	23 (47.9)	48 (47.1)	1.00	1.00
Completed high school	25 (52.1)	54 (52.9)	0.97 (0.49- 1.92)	1.64 (0.67-4.04)
Pregnancy Intended				
Planned pregnancy	8 (16.7)	27 (26.5)	1.00	1.00
Unintended pregnancy	40 (83.3)	75 (73.5)	1.80 (0.75-4.33)	1.16 (0.40-3.34)
Gravidity (m, sd)	2.5 (1.6)	2.6 (1.6)	0.84 (0.46- 1.54)	0.16 (0.13- 1.40)
Parity (m, sd)	1.3 (1.6)	1.3 (1.4)	1.22 (0.64- 2.33)	0.14 (0.74- 9.28)
Miscarriage				
Yes	12 (25.0)	22 (21.6)	1.00	1.00
No	36 (75.0)	80 (78.4)	0.83 (0.37-1.85)	0.36 (0.08-1.59)
Pregnancy Gestation				
Week 3-12	11 (22.9)	37 (36.3)	1.00	1.00
Week 13-28	27 (56.3)	56 (54.9)	1.62 (0.72-3.66)	1.56 (0.59-4.14)
Week 29- 40 and more	10 (20.8)	9 (8.8)	3.74 (1.21-11.50)	3.48 (0.89-13.67)

Mental Health				
Low Depression	17 (35.4)	75 (73.5)	1.00	1.00
High Depression	31 (64.6)	27 (26.5)	5.07 (2.42- 10.59)	6.42 (2.51-16.41)
Alcohol Use				
Low risk drinker	35 (72.9)	77 (75.5)	1.00	1.00
High risk drinker	13 (27.1)	25 (24.5)	1.14 (0.52- 2.50)	0.49 (0.18-1.34)
Childhood Trauma				
No childhood trauma	13 (27.1)	14 (13.7)	1.00	1.00
Yes, childhood trauma	35 (72.9)	88 (86.3)	0.35 (0.57- 3.52)	0.65 (0.23-1.86)
Community Violence				
Low community violence	8 (16.7)	48 (47.1)	1.00	1.00
High community violence	40 (83.3)	54 (52.9)	0.39 (0.96- 1.12)	2.48 (0.91-6.77)

4.6 Physical IPV in past 12 months

Investigations into the unadjusted and adjusted associations between participant characteristics and the experience of physical IPV in the past 12 months are reported in table 6. After adjusting for the effects of other variables, only women who were at risk for depression were more likely to experience physical IPV (OR= 4.42, CI 1.88-10.41) than women not at risk.

Table 5: Physical IPV in past 12 months

	% Yes	% No	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Age				
18-30	18 (40.9)	69 (65.1)	1.00	1.00
31- and older	26 (59.1)	37 (34.9)	0.55 (0.24- 1.23)	0.53 (0.17-1.60)
Race				
Black	34 (77.3)	49 (46.2)	1.00	1.00
Coloured	10 (22.7)	55 (51.9)	1.29 (0.63- 2.63)	1.44 (0.62-3.35)
Employment Status				
Employed	13 (29.5)	44 (41.5)	1.00	1.00
Unemployed	39 (88.6)	62 (58.5)	1.69 (0.80- 3.60)	1.04 (0.43-2.52)
Education				
Did not complete high school	23 (52.3)	48 (45.3)	1.00	1.00
Completed high school	21 (47.7)	58 (54.7)	0.76 (0.37- 1.53)	0.82 (0.35-1.93)
Pregnancy Intended				
Planned pregnancy	5 (11.4)	30 (28.3)	1.00	1.00
Unintended pregnancy	39 (88.6)	76 (71.7)	3.08 (1.11- 8.56)	2.70 (0.87-8.39)
Gravidity (m, sd)	2.4 (1.4)	2.6 (1.6)	0.90 (0.70- 1.14)	0.08 (0.11- 1.14)

Parity (m, sd)	1.2 (1.3)	1.3 (1.5)	0.92 (0.71- 1.20)	0.81 (0.87- 9.97)
Miscarriage				
Yes	11 (25.0)	23 (21.7)	1.00	1.00
No	33 (47.7)	83 (78.3)	0.83 (0.37-1.90)	0.23 (0.05-1.01)
Pregnancy Gestation				
Week 3-12	13 (29.5)	35 (33.0)	1.00	1.00
Week 13-28	25 (56.8)	58 (54.7)	1.16 (0.53-2.56)	0.89 (0.36-2.22)
Week 29- 40 and more	29 (13.6)	13 (12.3)	1.24 (0.39-3.96)	0.78 (0.20-3.01)
Mental Health				
Low Depression	16(36.4)	76 (71.7)	1.00	1.00
High Depression	28 (63.6)	30 (28.3)	4.43 (2.10- 9.34)	4.42 (1.88-10.41)
Alcohol Use				
Low risk drinker	28 (63.6)	84 (79.2)	1.00	1.00
High risk drinker	16 (36.4)	22 (20.8)	2.18 (1.01- 4.73)	1.42 (0.59-3.46)
Childhood Trauma				
No childhood trauma	10 (22.7)	17 (16.0)	1.00	1.00
Yes, childhood trauma	34 (77.3)	89 (84.0)	0.02 (0.98- 1.05)	0.98 (0.35-2.78)
Community Violence				
Low community violence	12 (27.3)	44 (41.5)	1.00	1.00
High community violence	32 (72.2)	62 (58.5)	0.03 (0.96- 1.12)	1.02 (0.41-2.56)

4.7 Sexual IPV in the past 12 months

Investigations into the unadjusted and adjusted associations between participant characteristics and the experience of Sexual IPV in the past 12 months are reported in table 7. After adjusting for the effects of other variables, women who reported experiencing community violence were more likely to report 12 month sexual IPV (OR= 4.42, CI 1.88-10.41), than women who reported no exposure to community violence (OR= 3.85, CI 1.14-13.08).

Table 6: Sexual IPV in the past 12 months

	% Yes	% No	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Age				
18-30	24 (80.0)	79 (65.8)	1.00	1.00
31- and older	6 (20.0)	41 (34.2)	0.48 (0.18-1.27)	0.57 (0.14-2.28)
Race				
Black	13 (43.3)	54 (45.0)	1.00	1.00
Coloured	17 (56.7)	64 (53.3)	1.17 (0.50-2.75)	1.15 (0.43-3.07)
Employment Status				
Employed	9 (30.0)	48 (40.0)	1.00	1.00
Unemployed	21 (70.0)	72 (60.0)	1.33 (0.53-3.32)	0.97 (0.35- 2.71)
Education				
Did not complete high school	13 (43.3)	58 (48.3)	1.00	1.00
Completed high school	17 (56.7)	62 (51.7)	1.45 (0.62-3.53)	1.30 (0.47-3.61)
Pregnancy Intended				
Planned pregnancy	5 (16.7)	30 (25.0)	1.00	1.00
Unintended pregnancy	25 (83.3)	90 (75.0)	1.50 (0.50- 4.48)	1.23 (0.38-4.02)
Gravidity (m, sd)	2.1 (1.2)	2.6 (1.6)	0.71 (0.31- 1.62)	0.13 (0.09- 1.36)
Parity (m, sd)	1.0 (1.4)	1.4 (1.4)	1.14 (0.47- 2.76)	0.20 (0.63- 8.43)
Miscarriage				
Yes	8 (26.7)	26 (21.7)	1.00	1.00
No	22 (73.3)	94 (78.3)	0.71 (0.27- 1.87)	0.30 (0.06-1.58)
Pregnancy Gestation				
Week 3-12	7 (23.3)	41 (34.2)	1.00	1.00
Week 13-28	22 (73.3)	61 (50.8)	2.11 (0.83-5.40)	2.08 (0.72-6.01)
Week 29- 40 and more	1 (3.3)	18 (15.0)	0.33 (0.04-2.84)	0.23 (0.02-2.30)
Mental Health				
Low Depression	13 (43.3)	79 (65.8)	1.00	1.00
High Depression	17 (56.7)	41 (34.2)	2.21 (0.93- 5.28)	2.15 (0.82-5.67)
Alcohol Use				
Low risk drinker	20 (66.7)	92 (76.7)	1.00	1.00
High risk drinker	10 (33.3)	28 (23.3)	1.30 (0.52- 3.28)	1.09 (0.38-3.13)
Childhood Trauma				
No childhood trauma	10 (33.3)	17 (14.2)	1.00	1.00
Yes, childhood trauma	20 (66.7)	103 (85.8)	0.01 (0.97- 1.05)	0.40 (0.14-1.20)
Community Violence				
Low community violence	4 (13.3)	52 (43.3)	1.00	1.00
High community violence	26 (86.7)	68 (43.3)	0.87 (1.00- 1.18)	3.85 (1.14-13.08)

CHAPTER 5

DISCUSSION

5.1 Introduction

The purpose of this chapter is to discuss the findings presented in Chapter 4. It will start with a discussion of the study's main findings concerning the prevalence rates and associated risk factors of IPV among pregnant woman who receive antenatal care from one MOU in the Western Cape. Thereafter, the study's limitations will be addressed. The chapter will conclude with implications for practice, training and policy development, as well as offering recommendations for future studies.

5.2 Major Findings

5.2.1 Prevalence of IPV

This study found a high prevalence rate of IPV among pregnant woman attending one MOU in the Western Cape. Almost half of the sample (44%) experienced IPV during their lifetime and in the past twelve months, with no significant differences between the two rates. In addition, respondents reported high levels of childhood trauma (n= 123, 82%) as well as witnessing community violence (n=94, 62%), while 38% and 25% screened as possible cases of depressive symptoms and alcohol dependence problems, respectively.

The prevalence rate for IPV found in this study is substantially higher than the global prevalence rates of IPV, which are estimated to range between 25% and 33% (Harling, Msisha & Subramanian, 2010; De Vries, et al, 2013; WHO, 2013), and an estimated 30% prevalence rate among pregnant women, globally (WHO, 2013). Differences between this study's prevalence rates and those found in HI countries such as the United States and UK are particularly stark, where prevalence rates in those settings are estimated to be between 5% and 33% (Koski, Stephenson & Koenig, 2011). Higher prevalence rates might be a result of factors associated with poverty; a lack of access to adequate resources for woman who experience abuse, when compared to those available in HI countries; as well as higher rates of violence among the general population (Gaylord-Harden, Dickson & Pierre, 2016).

However, when comparing the results from the current study to those of other LMI countries, similar ranges were found to exist, supporting findings that show that LMIC have elevated rates of IPV compared to HI countries. In LMI countries such as Bangladesh, Ethiopia, Turkey and Papua New Guinea, prevalence rates have been found to range between 45% and 67% (Abrahams & Jewkes, 2005), close to those found in this study. Prevalence rates for pregnant woman from African countries vary widely, with an upper range of 57% (Shamu, Abrahams, Temmerman, Musekiwa & Zarowsky, 2011). For example, in Eastern Nigeria, 40% of women were found to be victims of IPV at some point in their life (IIika et al.,2012). Other countries such as, Zimbabwe, revealed higher rates of IPV (60%) among postnatal woman (Shamu, Abrahams, Zarowsky, Shefer & Temmerman, 2013). The prevalence rates from this study are comparable to those found in these African studies.

Compared to data from South African studies conducted in other provinces, the current study`s prevalence rates of IPV among pregnant woman appear to be slightly lower. For example, the prevalence of IPV among women attending an antenatal clinic in Soweto, found that more than 50% of those women had experienced IPV during their current (Dunkle, et al., 2004). However other studies conducted in the Western Cape have found slightly higher rates of IPV (55%) among pregnant woman attending public health care facilities (Joyner & Mash, 2011).

In contrast to this, it is of interest to note that Joyner and Mash (2012) found that, within the South African primary healthcare sector, less than 10% of women who experience IPV are detected because of low rates of reporting/disclosure. This study found a higher rate of reportage, but even so, only one in five participants (20.7%) in this study reported ever having opened a case of assault with the police. It might be argued that, given the anonymity and confidentiality of most research methods, as well as the training that data collectors typically receive, reporting for the purposes of research is likely to be less threatening, making it easier for women to disclose their experiences. For this study, the data was collected by a Registered Counsellor: a professional trained to provide a safe and containing therapeutic environment. It is possible that this also made it easier for participants to disclose. Furthermore, low reporting rates are also likely to be due to perpetrators being known to or related to the victims, (Souverein, Ward, Visser & Burton, 2016).

Where forms of IPV were concerned, this study found that the most common form of abuse experienced by women in this sample were physical violence (n = 70, 46%), then general violence

[emotional abuse and controlling behaviours] (n = 66, 44%), followed by sexual violence (n = 24%). These findings are consistent with the findings of other studies. For example, archival data from a domestic violence assessment centre in the USA found that of those women who reported being abused, 70% reported physical abuse (Connor-Smith, Henning, Moore & Holdford, 2011). Another study (investigating infanticidal motives) also found that of the forty-three women interviewed, half (n = 20) of the participants had been subjected to a form of physical violence (Graham-Kevan & Archer, 2011). Of the participants in this study who indicated experiencing sexual violence in the past twelve months, 20% reported that the perpetrators were their intimate partners. This is slightly less when compared to South African statistics that show that up to 30% of victims reported the perpetrator as being an intimate partner or spouse ("Crime Statistics: Fact Sheet", 2017).

5.2.2 Risk factors

The study identified three main variables as risk factors for IPV in this sample of pregnant women. Significant associations were found to exist between IPV and depressive symptoms; IPV and unplanned pregnancies; as well as IPV and exposure to community violence. It is important to note that due to the cross-sectional nature of the study, no directional link between the identified risk factors and IPV can be inferred. The association between the identified risk factors and IPV in this study are less clear than other studies investigating causality.

5.2.2.1 Socio-demographic variables

The study found that of the many socio-demographic factors that were investigated, only one was found to be significantly associated with IPV. Unlike other studies (Brownridge, 2011; Capaldi, 2012) no association was found between IPV and variables such as level of education, being single or employment status. There were no significant between being women who were single or women who were in an intimate relationship. However, age was found to be a protective factor against IPV. Women who were younger (18 - 30 years old) were more likely to experience IPV than women who were older than 30. Research concerning age and IPV yield contradictory results (Bianchi, et al., 2014; Groves, et al., 2014). Arguably older women, might experience helplessness, or become detached form their circumstances because of many years of abuse (Burgos-Soto, 2014). Therefore, possibly disclosing less when compared to younger woman. Also, physical IPV is likely to decrease with age, but will often be replaced with other types of abuse such as emotional

or financial abuse, which women are less likely to report. In these instances, despite other forms of abuse, it is possible that women no longer view themselves as victims of abuse, given that physical violence has decreased or stopped altogether (Groves, et al., 2014).

5.2.2.2 Depressive symptoms

Commonly, studies have found that IPV during pregnancy is significantly associated with depressive symptoms (Adams, Bybee, Tolman, Sullivan, & Kennedy, 2013; Howard, Oram, Galley, Trevillion, & Feder, 2013). The current study found a significant association between physical IPV and depressive symptoms. The results showed that women with depressive symptoms were four times more likely to experience physical IPV. In addition, increased symptoms of depression were found to be significantly associated with any IPV in the previous twelve months. These findings are consistent with studies that have found mental health problems to be highly correlated with experiences of IPV (Rao, Horton & Raguraam, 2012; Iverson, 2015; Jackson, et al., 2015). Other studies conducted in Cape Town have highlighted a much higher association between IPV and depressive symptoms. For example, Hartley, et al. (2011) found that woman who experience abuse in their relationships over the past twelve months are eight times more likely to report depressive symptoms.

The association between IPV and depression appears to highlight the impact that violence has an on the mental health functioning of the individuals exposed to it. However, while no directional link between depressive symptoms and IPV can be inferred from this study's data, some research has shown that individuals with mental health problems, such as major depressive disorder, are at risk of becoming victims of abuse or ill-treatment (Elbogen & Johnson, 2009; Howard, Dean, Moran & Khalifeh, 2016; Shaw & Ullrich, 2015). In fact, a systematic review and meta-analysis of longitudinal studies investigating the association between IPV and depression found that IPV was associated with incident depressive symptoms and depressive symptoms with incident IPV, among women (Devries et al., 2013). It is not clear why depressive symptoms might cause IPV, however, Devries at al. (2013) posit that these symptoms may lead to poor choices in partner. Pregnant women are possibly made additionally vulnerable due to the high prevalence rates of depression during this time (Fisher, et al., 2012).

5.2.2.3 Unintended Pregnancy

The results from this study found that those women who reported experiencing general IPV in the previous twelve months were three times more likely to have an unplanned pregnancy than woman who reported experiencing no abuse. A noteworthy finding was that more than 70% of the study's respondents indicated that their present pregnancy was unplanned. In addition of those woman who reported any IPV in the past twelve months, 88% indicated that their current pregnancy was unintended. Studies investigating the association between IPV and unintended pregnancy are limited. However, it does appear to be a relatively widely-recognised risk factor (Ismayilova & El-Bassel, 2014; Mantell et al., 2009; Pallitto, Campbell, & O'Campo, 2005). One study in Brazil found that women who experienced violence before becoming pregnant were more than 1.5 times more likely to have unintended pregnancies (Azevêdo et al., 2013). A study in Colombia had similar results, where women were 1.4 times more likely to have an unintended pregnancy if they were in abusive relationships (Pallitto & O'Campo, 2004).

Given the limited research, it is not clear what the nature of the association is between unintended pregnancies and IPV. It is possible that women with violent partners' experience intimidation, control or coercion from their partners regarding their reproductive choices (Azevêdo et al., 2013; Pallitto et al., 2005). Unintended pregnancies could be a direct result of sexual violence (Pallitto & O`Campo, 2004). It is also possible that unintended pregnancies cause the levels of violence to increase (Graham-Kevan & Archer, 2011). Perpetrators of violence may become angry at the woman for falling pregnant, they may perceive it to be the woman's fault, thereby feeling a lack of control over their partner, whereby using violence as a means to feel in control (Hall, Chappell, Parnell, Seed, & Bewley, 2014; McCarry, 2010).

Notably, one study found that woman who reported unplanned pregnancies were 47% less likely to disclose abuse to a family, friend, professional or relative, compared to woman who reported having a planned pregnancy (Katiti, Sigalla, Rogathi, Manongi, & Mushi, 2016). The possible implication being that woman will not be able to receive the necessary support and guidance that often is associated with disclosing to someone trustworthy.

5.2.2.4 Community Violence

Communities with a poor or low socioeconomic status have been found to have elevated rates of violence (Bangdiwala et al., 2004). One might argue that high levels of frustrations associated with low socio-economic status, such as high levels of unemployment, could all be implicated in high levels of crime and violence, found in such communities (Raghavan, Mennerich, Sexton & James, 2006). Low-income communities in particular face problems with gangsterism and violent crimes, as was seen in the sample of women from this study.

Data from this study showed that women who reported experiencing community violence were four times more likely to report 12-month sexual IPV, than women who reported no exposure to community violence (OR= 3.85, CI 1.14-13.08). Very little research has been conducted to investigate the relationship between IPV and levels of community violence. However, recent data has shown that the Western Cape has significant levels of violence within its communities (Prinsloo, et al., 2016), while Cape Town was ranked 9th on the list of the fifty most violent communities in the world (Leggit, 2004; Weatstone, 2016). According to the National Mental Health Policy Framework for South Africa, communities with elevated rates of poverty have been identified as having higher rates of violence. This could explain the link between elevated levels of violence seen for woman attending the primary birthing facility in Mitchells Plain.

Arguably high levels of violence within a community, may contribute to normalising violent behaviour. Growing up witnessing violence, or being a frequent victim of violence could in turn create individuals to start becoming perpetrators of violence, thereby conforming to the notion that violence is an acceptable means to deal with daily life (Shields, Nadasen, & Pierce, 2013; Staggs & Riger, 2005). Individual in a community with elevated rates of violence could become desensitized, and in turn view violence as an ordinary means to life. In addition, violence may be seen as a normative construct of masculinity within communities that have significantly high rates of violence (McCarry, 2010). This could mean that the given community may conform to a patriarchal dominance.

5.3 Implications of findings: Policy, practice and training

Given the high prevalence rate of IPV among pregnant women found in this study as well as findings from other local studies, it is apparent that IPV should be recognised as a significant public health concern in South Africa. To help address this public health issue, appropriate measures and tools to address IPV need to be developed and institutionalised within the health care sector to address this phenomenon and provide the necessary support and assistance to woman who are victim to it.

Where policy is concerned, for South Africa, no recognition is given to IPV as a major concern for the public health sector, nor to the development for strategies to effectively deal with IPV within this sector. Currently the National Mental Health Policy framework for South Africa, makes no referral to IPV (Department of Health, 2013). This is strange given the high levels of mental health problems such as depression, PTSD and anxiety found among victims of IPV (Hartley et al., 2011; Heyningen et al., 2016; Lagdon, Armour, & Stringer, 2014). The policy does recognise that high levels of violence exist within the country and that it is a contributing factor to the current burden of disease (Prinsloo, Matzopoulos, Laubscher, Myers, & Bradshaw, 2016). In addition, the policy also recognises that violence increases the risk for mental illness, however again only referring to more a general and vague description, it fails to provide a strategy to sufficiently deal with violence in the health care sector.

Development for routine screening for IPV should become a matter of standard care at all MOUs across the country. Therefore, it should be tabled in public health policies. This will increase the detection rate by providing health workers with the means to identify victims of IPV in such settings. IPV management should be written into policy. In South Africa, the existing mental health policy framework insufficiently acknowledges IPV as a major concern for woman`s health. Though recognition is given for the need to improve current policies. Key issues are often found with regards to implementation of policy. Often the challenges are confined by the needs for others section of health care, such a HIV and Aids (National Mental- Health Policy Framework, 2013-2020). Mental health policies- require development for an improved framework and plans for implementation in order to sufficiently address IPV in the context of South Africa. For example, policy, could be adapted to include the use of a registered counsellor. They could conduct interviews with woman in antenatal setting, which providing a safe and comfortable space to

disclose. This could also be a key factor to aid more woman to disclose to a health care provider, thereby receiving adequate support, containment and guidance. During the study, it was observed that woman at the MOU were not given this opportunity when receiving antenatal care, since mental and emotional health are often seen as unrelated to antenatal care, which is focused on the development of the pregnancy.

In terms of practice, developing networks between government and community resources such as NGOs, shelters, counselling or social services or legal aid. Pamphlet or poster with contact details of places of safety for patients. Providing educational talks to women about impact of violence on their own physical and psychological well-being as well as baby's. How and where to get help when you are being abused, the avenues should be made available at all public health institutions.

Medical professionals such as the nursing and sister staff, or the doctors and breast feeding counsellors could be trained to effectively deal with IPV victimisation, during routine antenatal visits. When looking at the results of the current study, 44% of woman had experienced IPV during abuse and were only identified because of this study. Had the staff of the MOU been trained to deal with cases of IPV they would be able to identify such cases and provide the necessary support. They could be trained to observe for warming signs of abuse or what to do if a patient discloses abuse, a specific standard operating procedure needs to implemented in such settings. Appropriate assessment and intervention strategy needs to be developed to identify victims of IPV and link them to adequate resources.

5.4 Limitations

The study had several limitations. First, the sample size of the study is small making it difficult to generalise these results to broader populations. In addition, the results of the study may not be generalisable to the greater MOU population, as local generalisability is difficult to assume beyond convenience sample itself. The small size and sampling framework used also impact on the prevalence rates and comparison of this studies results with those of the broader literature. Given that the sample was drawn from only one site, it is difficult to extrapolate the results to the broader South African context. However, given that this MOU is one of the largest in the Western Cape (Western Cape Gov., 2016) it does offer some insight into the level of violence experienced by pregnant woman from this specific population and setting.

This study did not investigate the possibility of another abuser of IPV, other than an intimate partner. The study did not explore those variables which might not have been statistically significant, as having valuable contribution to the experience of IPV during pregnancy.

The researcher is fluent in both English and Afrikaans and therefore was only able to administer the measures in those languages. Feasibility issues compromised the use of Xhosa versions for the measures in this study. This restricted various participant from completing the measure in a language other than English or Afrikaans. The results of the study rely on self-report from participants, assuming each participant completed the questionnaire honestly. This study was cross-sectional and further research is needed in terms of a longitudinal research. Longitudinal studies could examine long term effect of risk factors associated with IPV. Additionally, it will be able to provide insight into the neonatal factors associated with IPV, such as low birth weight, substance use and bonding between mother and infant.

5.5 Conclusion and Recommendations

This is the first study of IPV that has been conducted with pregnant women in Mitchells Plain MOU. IPV among pregnancy is a global health problem, associated with a range of adverse outcomes, and requires urgent attention from the public health sectors. This study has shown high rates of IPV among pregnant woman attending a MOU in the Western Cape. These findings are consistent with findings from other SA studies. The results from this study identified three major risk factors associated with IPV during pregnancy. Due to the high levels of IPV among pregnant woman, health care institutions and practitioners need to find new ways to identify, contain and provide adequate intervention and support for the victims. Greater recognition of IPV during pregnancy could contribute to improved antenatal care, as well as enhanced policy development for appropriate intervention strategies.

Recommendations for future studies include:

- Conducting research at more than one MOU in the Western Cape. This will add to knowledge about the prevalence rates of IPV in the broader population of pregnant woman who experience IPV in the province.
- Use of a different sampling framework, to recruit a more representative sample of woman attending the MOU

- Follow up studies might be conducted that investigate the level of violence postnatally and whether there are differences before and after the birth. In addition, longitudinal studies might tell us more about the long-term impact that IPV has on the mother and child. This would help to inform the development of appropriate intervention strategies and programmes for these women. A greater recognition of IPV in pregnancy could also help contribute to improved antenatal care. The effectiveness of screening and intervention programmes should be investigated. Additional research may help determine appropriate intervention strategies available for pregnant woman who experience IPV. This data this could aid in detecting IPV and linking woman to resources such as NPOs, social services and support groups or legal services.
- Future studies might also focus on investigating whether violence increases with onset of pregnancy, as well as the role that unplanned pregnancies play in IPV patterns.
- Qualitative data is needed to gain insight into subjective construction of violence and abuse. This will provide much needed subjective insight into how woman perceive the experience of violence and which coping mechanism they use. This could aid in developing appropriate referral pathways.
- Of course, research focused on better understanding the perpetrators of IPV is also essential, especially during pregnancy. Examining their own exposure to community and other forms of violence might contribute to the development of suitable interventions for perpetrators of IPV.

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APPENDIX I

INFORMED CONSENT FORM

UNIVERSITY OF CAPE TOWN

Alan J Flisher Centre for Public Mental Health
Department of Psychiatry and Mental Health
46 Sawkins Road,
Rondebosch, 7700
Cape Town, South Africa

Project Title: The prevalence of interpersonal violence and the association with childhood trauma, alcohol use and exposure to community violence amongst women attending one midwife and obstetrics unit in the Western Cape.

Introduction: We are asking you to take part in a research study. The purpose of this study is to find out how many pregnant women have experienced intimate partner violence and to see if there is a relationship between the experience of childhood abuse, the experience of having seen a lot of violence in the community, and alcohol abuse during pregnancy. This study is part of a Master's study at the University of Cape Town. You qualify to take part in this study if you are a patient of the Mitchell's Plain MOU, you are 18 years or older, and are comfortable with answering questions in either English or Afrikaans (unfortunately, the researcher is only fluent in these languages). We hope to find 150 adult pregnant women to part take in this study.

What We're Asking of You: We will ask you to answer a number of questions about yourself (for example, whether you are married or working), and whether you have experienced any interpersonal violence (physical, sexual and emotional abuse). We will also be asking you if you have ever experienced abuse during your childhood and if you have abused any alcohol during your pregnancy. We will be asking you whether you have seen any violence within your neighbourhood. If you agree to participate in this study, it will take about 45 minutes of your time.

Risks or Discomforts - There are some risks to taking part in this study. Answering some of our questions may make you uncomfortable. If you feel that you would like to talk to a counsellor about your feelings you can approach the researcher with your details and she will arrange for an appointment with a counsellor for you on the same day. Your decision to take part or not take part in this study, or decision to drop out of the study will not affect your access to any services.

Benefits of Taking Part in The Study: If you take part in this study you will receive a once-off R30 Pick n Pay voucher as payment for your time and effort for participating in this study. You will also help us understand intimate partner violence among pregnant women which will help us develop an intervention to help other women in the future.

Taking Part In The Study Is Voluntary And Confidential: Taking part in this study is up to you. The answers that you give to our questions will be used for research purposes only. Apart from the researcher, no one will know that the answers you gave belonged to you**.** Your personal information will be kept private. If you decide you don't want to be in the study that is okay. If you don't want to answer a certain question during the study, that is also okay. If you choose not to take part or if you drop out, we will still give you referrals to counselling services you may need.

Privacy: Anyone who is working with any of the information you give us has to sign an agreement not to share what you tell us. Your answers will be given a special number instead of your name. No one else will know these are your answers. In research reports, your answers will always be grouped with other people's answers or disguised to protect you from being recognized. All confidential data will be stored in a double-locked file cabinet. The questionnaires and consent forms will be destroyed after one year of the completion of study activities.

Who to Contact With Questions: If you have any questions about the study please contact the researcher Megan Malan, megz120989@gmail.com or 073 516 8491. or supervisor Dr. Katherine Sorsdahl, e-mail: katherine.sorsdahl@uct.ac.za.

If you are unhappy or have concerns about participating in the study, please feel free to contact the Faculty of Health Sciences Human Research Ethics Committee by Telephone: (021) 406 6492; fax: (021) 406 6411; or email: (*Marc*.*Blockman*@*uct*.ac.za). Their offices are located on floor E52, Room 23 in the Old Main Building of Groote Schuur Hospital, Observatory, 7925.

Declaration by participant

By signing below, I ……..…… agree to take part in the research study explained to me

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressured to take part. I also understand that I do not give up any rights by signing below.
- I may choose to leave the study at any time and I will not be penalised or prejudiced in any way.
- I have received an unsigned copy of this form to keep.

Signed at (*place*) .....…..……. on (*date*) ……...……..

.....	.....
Signature of participant	Signature of UCT researcher

APPENDIX II

INGELIGTE TOESTEMMINGS VORM

UNIVERSITY OF CAPE TOWN

Alan J Flisher Centre for Public Mental Health
Department of Psychiatry and Mental Health
46 Sawkins Road,
Rondebosch, 7700
Cape Town, South Africa

Projek Titel: The prevalence of interpersonal violence and the association with childhood trauma, alcohol use and exposure to community violence amongst women attending one midwife and obstetrics unit in the Western Cape.

Inleiding: Ons vra u om deel te neem aan 'n navorsingstudie. Die doel van hierdie studie is om uit te vind hoeveel swanger vroue geweld in intieme verhoudings ervaar, en om te sien of daar 'n verband is tussen die ervaring van kindermishandeling, die ervaring en blootstelling aan baie geweld in die gemeenskap, en alkoholmisbruik tydens swangerskap. Hierdie studie is deel van 'n Meesters-studie aan die Universiteit van Kaapstad. U kwalifiseer om deel te neem in hierdie studie as u 'n pasiënt van die Mitchells Plain MOU is, as u 18 jaar of ouer is, en is gemaklik om die vrae in Engels of Afrikaans te beantwoord (ongelukkig, is die navorser net vlot in hierdie tale). Ons hoop 150 volwasse swanger vroue te vind om deel te neem aan hierdie studie.

Wat ons van u vra: Ons sal u vra om 'n aantal vrae oor jouself te beantwoord (byvoorbeeld, of u getroud is of werk), en of u enige interpersoonlike geweld (fisiese, seksuele en emosionele mishandeling) al ervaar het. Ons sal ook vra of u al ooit mishandeling ervaar tydens u kinderjare en of u enige alkohol misbruik het tydens u swangerskap. Ons sal u vra of u al enige geweld in u gemeenskap ervaar het. As u saamstem om deel te neem in hierdie studie, sal dit ongeveer 45 minute van jou tyd neem.

Risiko's of ongerief - Daar is sekere risiko's verbonde deur deel te neem aan hierdie studie. Die beantwoording van sommige van ons vrae kan u ongemaklik laat voel. As u voel dat u met 'n berader oor u gevoelens wil praat kan u die navorser benader met u besonderhede en sy sal reël vir 'n afspraak met 'n berader vir u op dieselfde dag. U besluit om deel te neem of nie deel te neem aan hierdie studie, of besluit om uit te val van die studie sal nie u toegang tot enige dienste beïnvloed nie.

Voordele van deelname in die studie: As u deel neem in hierdie studie sal u eenmaal `n R30 Pick n Pay geskenk bewys kry vir u tyd en moeite vir die deelname in hierdie studie**.** U sal ook help bydra om meer te

verstaan onder geweld in intieme verhoudings onder swanger vroue wat ons sal help om n program of ondersteunings dienste te kan ontwikkel en stig om ander vroue in die toekoms te help.

Deelname aan die studie is vrywillig en vertroulik: Deelname in hierdie studie is u vrywillige keuse. Die antwoorde wat u aan ons vrae gee sal slegs vir navorsing doeleindes gebruik word. Afgesien van die navorser, sal niemand weet dat die antwoorde wat jy gegee het aan u behoort nie. U persoonlike inligting sal vertroulik gehou word. As u besluit u wil nie meer deelneem aan die studie nie sal dit in orde wees. As u nie tydens die studie 'n sekere vraag wil beantwoord nie, sal dit ook in orde wees. As u kies om nie deel te neem nie of as u tydens die studie wil uitval, sal ons nogsteeds vir u die nodige verwysings na berading dienste gee.

Privaatheid: Enige iemand wat werk met enige van die inligting wat jy aan ons gee sal 'n ooreenkoms teken om nie te deel wat u met ons deel nie. U antwoorde sal 'n spesiale nommer gegee word in plaas van u naam. Niemand anders sal weet dit is u antwoorde nie. In die navorsing verslae, sal u antwoorde altyd met ander mense se antwoorde gegroepeer word of verbloem word om **u** te beskerm. Alle vertroulike inligting sal in 'n dubbel-toegesluit lêer kabinet geberg word. Die vraelyste en toestemming vorms sal vernietig word na 'n jaar van die bestudering van die aktiwiteite.

Wie om te kontak met vrae: As u enige vrae het oor die studie, kontak die navorser Megan Malan, megz120989@gmail.com of 073 516 8491. of toesighouer Dr. Katherine Sorsdahl, e-pos: katherine.sorsdahl@uct.ac.za.

As u ongelukkig is of kommer oor deelname aan die studie, voel asseblief vry om die Fakulteit van Gesondheidswetenskappe en Menslike Navorsingsetiekkomitee te kontak by Tel: (021) 406 6492; Faks: (021) 406 6411; of e-pos: (Marc.Blockman@uct.ac.za). Hul kantore is geleë op die vloer E52, Kamer 23 in die Ou Hoofgebou van Groote Schuur Hospitaal, Observatory, 7925.

Verklaring van deelnemer

Deur die ondertekening van onder gee, Ek ..... instemming om deel te neem in die navorsingstudie aan my verduidelik.

Ek verklaar dat:

• Ek het gelees of daar was vir my gelees hierdie inligting en toestemming vorm en dit is in 'n taal wat ek vlot en gemaklik in kommunikeer.

• Ek het 'n kans om vrae te vra en al my vrae is voldoende beantwoord.

• Ek verstaan dat deelname aan hierdie studie is vrywillig en ek is nie onder druk geplaas om deel te neem nie. Ek verstaan ook dat ek nie enige regte opgee deur die ondertekening hieronder nie.

• Ek kan kies om die studie op enige tyd om te verlaat en ek sal nie gestraf word of benadeel word nie.

• Ek ontvang 'n ongetekende afskrif van hierdie vorm om te hou.

Handtekening van deelnemer Handtekening van UCT navorser

APPENDIX III

Demographic Information

Age: _____

RACE	B	C	W	I	Other

Marital Status: _____ Home Language: _____

Highest level of education finished: _____

Employment status:_____

Was this pregnancy planned: YES/NO

Gravidity: _____ Parity: _____ Misc: _____

How far pregnant are you (weeks): _____ How many (live) children do you have: _____

Have you ever opened a case at the police station for assault: YES/NO

APPENDIX IV

WHO Interpersonal Violence Questionnaire (IPVQ)

Question	NEVER 1	ONCE 2	FEW 3	MANY 4
Has a current or previous husband or boyfriend ever insulted you or made you feel bad about yourself? Did this happen many times, a few times, once or did it not happen?				
Has a current or previous husband or boyfriend ever belittled or humiliated you in front of other people? Did this happen many times, a few times, once or did it not happen?				
Has a current or previous husband or boyfriend ever done things to scare or intimidate you on purpose for example by the way he looked at you, by yelling and smashing things? Did this happen many times, a few times, once or did it not happen?				
Has a current or previous husband or boyfriend ever threatened to hurt you? Did this happen many times, a few times, once or did it not happen?				
Have any of these things happened in the past 12 months?				

READ: PHYSICAL ABUSE

Men often fight with their girlfriends/wives and often these fights get physical. I am going to ask some questions about this because we want to learn more about what women experience in their lives. I want you to speak freely and remember that everything you say will be confidential.

Question	NEVER 1	ONCE 2	FEW 3	MANY 4

Has a current or previous husband or boyfriend ever slapped you or threw something at you which could hurt you? Did this happen many times, a few times, once or did it not happen?				
Has a current or previous husband or boyfriend ever pushed or shoved you? Did this happen many times, a few times, once or did it not happen?				
Has a current or previous husband or boyfriend ever hit you with a fist or with something else which could hurt you? Did this happen many times, a few times, once or did it not happen?				
Has a current or previous husband or boyfriend ever kicked, dragged, beat, choke or burnt you? Did this happen many times, a few times, once or did it not happen?				
Has a current or previous husband or boyfriend ever threatened to use or actually use a gun, knife or other weapon against you? Did this happen many times, a few times, once or did it not happen?				
Have any of these things happened in the past 12 months?				

READ: **SEXUAL ABUSE**

There are also other things which women experience that they sometimes do not talk about. I want you to speak freely and remember that everything you say will be confidential.

Question	**NEVER** **1**	**ONCE** **2**	**FEW** **3**	**MANY** **4**
Has a current or previous husband or boyfriend ever physically forced you to have sex when you did not want to? Did this happen many times, a few times, once or did it not happen?				
Have you ever have sex with a current or previous husband or boyfriend when you did not want to because you were afraid of what he might do? Did this happen many times, a few times, once or did it not happen?				
Has a current or previous husband or boyfriend ever forced you to do something sexual that you found degrading or humiliating? Did this happen many times, a few times, once or did it not happen?				
Have any of these things happened in the past 12 months?				

APPENDIX V

Alcohol Use Disorder Identification Test (AUDIT)

READ: Now I am going to read a number of statements. Each one describes a way that you might (or might not) feel about your drinking.

	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
2. How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than Monthly	Monthly	Weekly	Daily or almost always	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or almost always	
5. I was drinking /doing drugs too much at one time, but	Never	Less than Monthly	Monthly	Weekly	Daily or almost always	
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than Monthly	Monthly	Weekly	Daily or almost always	

7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost always	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost always	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

APPENDIX VI

Exposure to Community violence questionnaire

***(Adapted from Children's exposure to community violence questionnaire)** READ: Sometimes things happen in a neighbourhood which may cause people to be afraid or get hurt. I will be asking you a few questions about such activities in your neighbourhood.

Question	Never 1	Once or Twice 2	A few times 3	Many times 4
1. Have you heard guns being shot in your neighbourhood?				
2. Have you ever seen someone being shot?				
3. Have you ever seen someone pull a gun on another person?				
4. Have you ever seen a gun in your house?				
5. Have you ever seen someone being arrested?				
6. Have you ever seen drugs deals?				
7. Have you ever seen someone being beaten up?				
8. Has your house ever been broken into?				
9. Have you ever seen someone being stabbed?				
10. Have you ever seen gangs in your neighbourhood?				
11. Have you ever seen someone being stabbed or shot in your home?				
12. Have you seen alcohol consumption in your neighbourhood?				

APPENDIX VII

Childhood Trauma Questionnaire (CTQ-SF)

READ: These questions ask about some of your experiences growing up **as a child and a teenager**. For each question, circle the number that best describes how you feel. Although some of these questions are of a personal nature, please try to answer as honestly as you can. Your answers will be kept confidential.

When I was growing up, …	**Never True**	**Rarely True**	**Sometimes True**	**Often True**	**Very Often True**
1. I didn't have enough to eat.	**1**	**2**	**3**	**4**	**5**
2. I knew there was someone to take care of me and protect me	**1**	**2**	**3**	**4**	**5**
3. People in my family called me things like "stupid", "lazy", or "ugly".	**1**	**2**	**3**	**4**	**5**
4. My parents were too drunk or high to take care of me.	**1**	**2**	**3**	**4**	**5**
5. There was someone in my family who helped me feel important or special.	**1**	**2**	**3**	**4**	**5**
6. I had to wear dirty clothes.	**1**	**2**	**3**	**4**	**5**
7. I felt loved.	**1**	**2**	**3**	**4**	**5**
8. I thought that my parents wished I had never been born.	**1**	**2**	**3**	**4**	**5**
9. I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	**1**	**2**	**3**	**4**	**5**
10. There was nothing I wanted to change about my family.	**1**	**2**	**3**	**4**	**5**
11. People in my family hit me so hard that it left bruises or marks.	**1**	**2**	**3**	**4**	**5**
12. I was punished with a belt, a board, a cord, or some hard object.	**1**	**2**	**3**	**4**	**5**
13. People in my family looked out for each other.	**1**	**2**	**3**	**4**	**5**
14. People in my family said hurtful or insulting things to me.	**1**	**2**	**3**	**4**	**5**

15. I believe that I was physically abused.	**1**	**2**	**3**	**4**	**5**
16. I had the perfect childhood.	**1**	**2**	**3**	**4**	**5**
17. I got hit or beaten so badly that it was noticed by someone like a teacher, neighbour, or doctor.	**1**	**2**	**3**	**4**	**5**
18. I felt that someone in my family hated me.	**1**	**2**	**3**	**4**	**5**
19. People in my family felt close to each other.	**1**	**2**	**3**	**4**	**5**
20. Someone tried to touch me in a sexual way, or tried to make me touch them.	**1**	**2**	**3**	**4**	**5**
21. Someone threatened to hurt me or tell lies about me unless I did something sexual with them.	**1**	**2**	**3**	**4**	**5**
22. I had the best family in the world.	**1**	**2**	**3**	**4**	**5**
23. Someone tried to make me do sexual things or make me watch sexual things.	**1**	**2**	**3**	**4**	**5**
24. Someone molested me.	**1**	**2**	**3**	**4**	**5**
25. I believe that I was emotionally abused.	**1**	**2**	**3**	**4**	**5**
26. There was someone to take me to the doctor if I needed it.	**1**	**2**	**3**	**4**	**5**
27. I believe that I was sexually abused	**1**	**2**	**3**	**4**	**5**
28. My family was a source of strength and support.	**1**	**2**	**3**	**4**	**5**

APPENDIX VIII

Edinburgh Depression Scale

For each question, there are four answers to choose from. Please choose the answer that best describes how you have been feeling in the last 7 days, not just today.

During the last 7 days:

1. I have been able to laugh and see the funny side of things

- ☐ (0) As much as I always could
- ☐ (1) Not quite so much now
- ☐ (2) Definitely not so much now
- ☐ (3) Not at all

2. I have looked forward with enjoyment to things

- ☐ (0) As much as I ever did
- ☐ (1) Rather less than I used to
- ☐ (2) Definitely less than I used to
- ☐ (3) Hardly at all

3. I have blamed myself unnecessarily when things went wrong

- ☐ (3) Yes, most of the time
- ☐ (2) Yes, some of the time
- ☐ (1) Not very often
- ☐ (0) No, never

4. I have been anxious or worried for no good reason

- ☐ (0) No, not at all
- ☐ (1) Hardly ever
- ☐ (2) Yes, sometimes
- ☐ (3) Yes, very often

5. I have felt scared or panicky for no very good reason

- ☐ (3) Yes, quite a lot
- ☐ (2) Yes, sometimes

- ☐ (1) No, not much
- ☐ (0) No, not at all

6. Things have been getting on top of me

- ☐ (3) Yes, most of the time I haven't been able to cope at all
- ☐ (2) Yes, sometimes I haven't been coping as well as usual
- ☐ (1) No, most of the time I have coped quite well
- ☐ (0) No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping

- ☐ (3) Yes, most of the time
- ☐ (2) Yes, sometimes
- ☐ (1) Not very often
- ☐ (0) No, not at all

8. I have felt sad or miserable

- ☐ (3) Yes, most of the time
- ☐ (2) Yes, quite often
- ☐ (1) Not very often
- ☐ (0) No, not at all

9. I have been so unhappy that I have been crying

- ☐ (3) Yes, most of the time
- ☐ (2) Yes, quite often
- ☐ (1) Only occasionally
- ☐ (0) No, never

10. The thought of harming myself has occurred to me (refer if yes)

- ☐ (3) Yes, quite often
- ☐ (2) Sometimes
- ☐ (1) Hardly ever
- ☐ (0) Never

SCORE: _____

APPENDIX IX

Demografiese Inligting

Ouderdom: _____

RAS	S	K	W	I	Ander

Huiweliks Status: _____ Huis Taal: _____

Hoogste vlak van opvoeding wat voltooi is: _____

Indiensneming status:_____

Was hierdie swangerskap beplan: JA/NEE

Gravidity: _____ Parity: _____ Misc: _____

Hoe vêr swanger is u (weke): _____ Hoeveel (lewendige) kinders het u: _____

Het jy al ooit 'n saak by die polisie stasie vir aanranding geopen: JA/NEE

APPENDIX X

WHO Interpersonal Violence Questionnaire – AFRIKAANS

Vraag	**NOOIT** **1**	**EENMAAL** **2**	**SOMS** **3**	**GEREELD** **4**
Het n huidige of voormalige lewensmaat/man of kêrel al ooit vir jou beledig of vir jou sleg laat voel oor jouself? Het dit al baie gebeur, `n paar keer gebeur, een keer gebeur, of nie gebeur nie?				
Het `n huidige of voormalige lewensmaat/man of kêrel al ooit vir jou verkleineer of verneder in die teenwoordigheid van ander mense? Het dit al baie gebeur, `n paar keer gebeur, een keer gebeur, of nie gebeur nie?				
Het `n huidge of voormalige lewensmaat/man of kêrel al iets gedoen om jou opsetlik bang te maak of intimideer, byvoorbeeld deur die manier waarop hy na jou kyk, of deur te skree en goed te breek? Het dit al baie gebeur, `n paar keer gebeur, een keer gebeur, of nie gebeur nie?				
Het `n huidige of voormalige lewensmaat/man of kêrel ooit gedreig om jou seer te maak? Het dit al baie gebeur, `n paar keer gebeur, een keer gebeur, of nie gebeur nie?				
Het enige van die gebeure in die afgelope 12 maande plaasgevind?				

LEES: FISIESE GEWELD

Mans sal gereeld met hul vriendinne/vrouens baklei en dikwels sal hierdie bakleierye fisies raak. Ek gaan vir jou `n paar vrae vra hieroor want ons wil meer uitvind oor wat vrouens ervaar in hul lewens. Ek will hê jy moet openlik gesels en onthou alles way jy sê streng vertroulik sal bly.

Vraag	**NOOIT** **1**	**EENMAAL** **2**	**SOMS** **3**	**GEREELD** **4**
Het `n hudige of voormalige lewensmaat/man of kêrel al ooit vir jou geslaan, of met iets gegooi wat jou kon seer maak? Het dit al baie gebeur, `n paar keer gebeur, een keer gebeur, of nie gebeur nie?				
Het `n hudige of voormalige lewensmaat/man of kêrel al ooit vir jou gestoot of gestamp? Het dit al baie gebeur, `n paar keer gebeur, een keer gebeur, of nie gebeur nie?				
Het `n hudige of voormalige lewensmaat/man of kêrel al ooit vir jou met die vuis geslaan of met `n iets wat jou kon seer maak? Het dit al baie gebeur, `n paar keer gebeur, een keer gebeur, of nie gebeur nie?				
Het `n hudige of voormalige lewensmaat/man of kêrel al ooit vir jou geskop, gesleep, aangerand, gewurg of gebrand? Het dit al baie gebeur, `n paar keer gebeur, een keer gebeur, of nie gebeur nie?				
Het `n hudige of voormalige lewensmaat/man of kêrel al ooit gedreig om `n vuurwapen, mes of ander wapen teen jou te gebruik of al een so wapen teen jou gebruik? Het dit al baie gebeur, `n paar keer gebeur, een keer gebeur, of nie gebeur nie?				
Het enige van die voorvalle in die afgelope 12 maande gebeur?				

LEES: **SEXUELE GEWELD**

Daar is ook ander gebeure wat vrouens ervaar, waaroor hulle soms nie wil praat nie. Ek wil hê jy moet vrylik praat en onthou alles wat jy hier sê bly streng vertroulik.

Vraag	**NOOIT** **1**	**EENMAAL** **2**	**SOMS** **3**	**GEREELD** **4**
Het `n hudige of voormalige lewensmaat/man of kêrel al ooit vir jou fisies forseer om seksuele omgang (seks) met hom te hê, wanneer jy nie wou nie? Het dit al baie gebeur, `n paar keer gebeur, een keer gebeur, of nie gebeur nie.				
Het jy al ooit seksuele omgang (seks) met `n huidige of voormalige lewensmaat/man of kêrel gehad, al wou jy nie, want jy was bang oor wat hy dalk sou doen? Het dit al baie gebeur, ‘n paar keer gebeur, een keer gebeur, of nie gebeur nie?				
Het `n hudige of voormalige lewensmaat/man of kêrel jou al ooit forseer om iets seksueel te doen wat jy verneederend of humilheerend gevind het? Het dit al baie gebeur, `n paar keer gebeur, een keer gebeur, of nie gebeur nie?				
Het die gebeure in die afgelope 12 maande plaasgevind?				

APPENIX XI

AUDIT- AFRIKAANS

LEES: Gedurende die laaste 12maande, het jy enige drankies met alkohol gehad? □ Ja □ Nee
INDIEN JA, ANTWOORD ASSSEBLIEF VRAE 1-10 HIERONDER

	0	1	2	3	4	Aantal
1. Hoe gereeld drink jy drankies met alkohol in?	Nooit	Minder as 1 per maand	2-4 per maand	2-3 maal per week	4 of meer maal per week	
2. Hoeveel drankies met alkohol sal jy op `n gewone dag geniet wanneer jy drink?	1 of 2	4 of 4	5 of 6	7 tot 9	10 of meer	
3. Hoe gereeld sal jy ses of meer drankies drink op een slag?	Nooit	Minder as 1 maal per maand	Maandeliks	Weekliks	Daagliks of amper daagliks	
4. Hoe gereeld gedurende die laaste jaar, het jy gevind dat jy nie kan ophou drink toe jy eers begin het nie?	Nooit	Minder as 1 maal per maand	Maandeliks	Weekliks	Daagliks of amper daagliks	
5. Hoe gereeld, gedurende die laaste jaar het jy nie gedoen wat normaalweg van jou verwag om te doen omdat jy gedrink het nie?	Nooit	Minder as 1 maal per maand	Maandeliks	Weekliks	Daagliks of amper daagliks	
6. Hoe gereeld gedurende die laaste jaar, het jy n` “regmaker” nodig gehad om jouself aand die gang te kry na `n aand van baie drink?	Nooit	Minder as 1 maal per maand	Maandeliks	Weekliks	Daagliks of amper daagliks	
7. Hoe gereeld gedurende die laaste jaar het jy skuldig gevoel nadat jy gedrink het?	Nooit	Minder as 1 maal per maand	Maandeliks	Weekliks	Daagliks of amper daagliks	
8. Hoe gereeld gedurende die laaste jaar, kon jy nie onthou wat die vorige aand gebeur het nie, omdat jy gedrink het?	Nooit	Minder as 1 maal per maand	Maandeliks	Weekliks	Daagliks of amper daagliks	
9. Het jy of iemand anders al ooit seergekry as gevolg van jou drinkery?	Nee		Ja, maar nie gedurende die laaste jaar nie		Ja geduren de die laaste jaar	
10. Was `n familielid , vriend, dokter of ander gesondheidswerker al ooit bekommerd oor jou	Nee		Ja, maar nie gedurende		Ja, geduren de die	

drinkery,of voorgestel dat jy minder drink?			die laaste jaar nie		laaste jaar	

APPENDIX XII

Gemeenskapsgeweld blootstelling.

LEES: Soms gebeur dinge in ‘n buurt wat veroorsaak dat mense bang raak of seer kry. Ek gaan ‘n paar vrae vra oor sulke gebeurtenisse in u buurt.

Question	Nooit 1	Een of Twee keer 2	‘n Paar keer 3	Dikwels 4
1. Het u al ooit geweerskote gehoor in u buurt?				
2. Het u al ooit gesien hoe iemand geskiet word?				
3. Het u al ooit gesien dat iemand ‘n geweer op ‘n ander **persoon** mik?				
4. Het u al ooit ‘n geweer in u huis gesien?				
5. Het u al ooit gesien hoe iemand gearresteer word?				
6. Het u al ooit ‘n dwelm ‘deal’/transaksie gesien?				
7. Het u al ooit gesien hoe iemand erg geslaan word?				
8. Is u huis al ooit beroof?				
9. Het u al ooit gesien hoe iemand met ‘n mes gesteek word?				
10. Het u al ooit ‘gangs’/bendes in u buurt gesien?				
11. Het u al ooit gesien hoe iemand in u huis geskiet of met ‘n mes gesteek word?				
12. Het u al ooit dranke inname in u buurt gesien?				

TOTAAL: _____

APPENDIX XIII

CTQ: AFRIKAANS

Instruksies: Hierdie vrae handel oor sommige ervarings wat u **as kind en tiener** gehad het. Vir elke vraag, omkring die nommer wat die beste beskryf hoe u voel. Hoewel sommige van hierdie vrae van persoonlike aard is, probeer asseblief om so eerlik as moontlik te beantwoord. U antwoorde sal vertroulik gehou word.

As kind, …	**Nooit waar nie**	**Selde waar**	**Soms waar**	**Dikwels waar**	**Baie dikwels**
1. Het ek nie genoeg gehad om te eet nie.	**1**	**2**	**3**	**4**	**5**
2. Het ek geweet daar was iemand om my te versorg en te beskerm.	**1**	**2**	**3**	**4**	**5**
3. Het mense in my gesin my “dom”, “lui” of “lelik” genoem.	**1**	**2**	**3**	**4**	**5**
4. Was my ouers te dronk of onder die invloed van dwelms om die gesin te versorg.	**1**	**2**	**3**	**4**	**5**
5. Was daar iemand in my gesin wat my belangrik of spesiaal laat voel het.	**1**	**2**	**3**	**4**	**5**
6. Moes ek vuil klere dra.	**1**	**2**	**3**	**4**	**5**
7. Het ek geliefd gevoel.	**1**	**2**	**3**	**4**	**5**
8. Het ek gedink dat my ouers wens dat ek nooit gebore is nie.	**1**	**2**	**3**	**4**	**5**
9. Is ek so hard deur iemand in die gesin geslaan dat ek ‘n dokter moes sien of na die hospital moes gaan.	**1**	**2**	**3**	**4**	**5**
10. Was daar niks wat ek aan my gesin wou verander nie.	**1**	**2**	**3**	**4**	**5**
11. Het die mense in my gesin my so hard geslaan dat ek kneusplekke of merke gehad het.	**1**	**2**	**3**	**4**	**5**
12. Was ek gestraf met ‘n lyfgordel (belt), ‘n plank, ‘n draad, of so ‘n harde voorwerp.	**1**	**2**	**3**	**4**	**5**

13. Het die mense in my gesin na mekaar omgesien.	**1**	**2**	**3**	**4**	**5**
14. Het mense in my gesin my beledig of dinge gesê wat my hartseer gemaak het.	**1**	**2**	**3**	**4**	**5**
15. Glo ek, ek is fisies misbruik.	**1**	**2**	**3**	**4**	**5**
16. Het ek die volmaakte kinderjare gehad.	**1**	**2**	**3**	**4**	**5**
17. Is ek so hard geslaan dat dit deur iemand soos ‘n onderwyser, buurman of dokter opgemerk is.	**1**	**2**	**3**	**4**	**5**
18. Het ek gevoel dat iemand in my gesin my gehaat het.	**1**	**2**	**3**	**4**	**5**
19. Het die mense in my gesin geheg aan mekaar gevoel.	**1**	**2**	**3**	**4**	**5**
20. Het iemand aan my probeer vat op ‘n seksuele manier, of het probeer maak dat ek aan hulle vat.	**1**	**2**	**3**	**4**	**5**
21. Het iemand gedreig om my seer te maak of om leuens oor my te vertel tensy ek iets seksueel met hulle doen.	**1**	**2**	**3**	**4**	**5**
22. Het ek die beste gesin in die wêreld gehad.	**1**	**2**	**3**	**4**	**5**
23. Het iemand my seksuele dinge laat doen of seksuele dinge laat kyk.	**1**	**2**	**3**	**4**	**5**
24. Het iemand my gemolesteer.	**1**	**2**	**3**	**4**	**5**
25. Glo ek, ek is emosioneel misbruik.	**1**	**2**	**3**	**4**	**5**
26. Was daar iemand om my dokter toe te neem as dit nodig was.	**1**	**2**	**3**	**4**	**5**
27. Glo ek, ek is seksueel gemolesteer.	**1**	**2**	**3**	**4**	**5**
28. Was my gesin ‘n bron van krag en ondersteuning.	**1**	**2**	**3**	**4**	**5**

APPENDIX XIV

Edinburgh Depression Scale: AFRIKAANS

Daar is 'n keuse van vier antwoorde vir elke vraag. Omsirkel asseblief die antwoord wat die beste beskryf hoe jy gedurende die afgelope sewe dae gevoel het, nie net hoe jy nou vandag voel nie.

Gedurende die afgelope 7 dae:

1. Kon ek lag en die snaakse kant van dinge sien

- ☐ (0) So maklik soos ek altyd kon
- ☐ (1) Nie heeltemal so maklik nie
- ☐ (2) Defnitief nie so maklik nie
- ☐ (3) Glad nie

2. Kon ek met genot na dinge uitsien

- ☐ (0) So baie soos ek altyd het
- ☐ (1) 'n Bietjie minder as wat ek altyd het
- ☐ (2) Baie minder as wat ek gewoonlik het
- ☐ (3) Amper glad nie

3. Het ek myself blameer wanneer dinge verkeerd gaan, al was dit nie my skuld nie

- ☐ (3) Ja, meeste van die tyd
- ☐ (2) Ja, soms
- ☐ (1) Nee, nie dikwels nie
- ☐ (0) Nee, nooit nie

4. Was ek bekommerd en ek weet nie hoekom nie

- ☐ (0) Nee, glad nie
- ☐ (1) Omtrent nooit
- ☐ (2) Ja, soms
- ☐ (3) Ja, dikwels

5. Het ek bang en paniekerig gevoel en ek weet nie hoekom nie

- ☐ (3) Ja, nogal baie
- ☐ (2) Ja, soms
- ☐ (1) Nee, nie so baie nie

- ☐ (0) Nee, glad nie

6. Het ek gesukkel om dinge te hanteer

- ☐ (3) Ja, meeste van die tyd sukkel ek om dinge te hanteer
- ☐ (2) Ja, soms hanteer ek dinge nie so maklik soos gewoonlik nie
- ☐ (1) Nee, meestal hanteer ek dinge redelik goed
- ☐ (0) Nee, ek hanteer dinge so goed as wat ek altyd kon

7. Was ek so ongelukkig dat ek sleg geslaap het

- ☐ **(3) Ja, meeste van die tyd**
- ☐ **(2) Ja, soms**
- ☐ **(1) Nie dikwels nie**
- ☐ **(0) Nee, glad nie**

8. Het ek hartseer en ongelukkig gevoel

- ☐ (3) Ja, meeste van die tyd
- ☐ (2) Ja, nogal dikwels
- ☐ (1) Nie dikwels nie
- ☐ (0) Nee, nooit nie

9. Was ek so hartseer dat ek gehuil het

- ☐ (3) Ja, meeste van die tyd
- ☐ (2) Ja, dikwels
- ☐ (1) Net soms
- ☐ (0) Nee, nooit

10. Die idee om myself leed aan te doen het al by my opgekom

- ☐ (3) Ja, nogal dikwels
- ☐ (2) Soms
- ☐ (1) Amper nooit
- ☐ (0) Nooit

TELLING: _____